

South African Medical Journal



S.-A. Tydskrif vir Geneeskunde

Organ of the Medical Association of South Africa

Blad van die Mediese Vereniging van Suid-Afrika

Incorporating the South African Medical Record and the
Medical Journal of South Africa

Waarby ingelyf is die South African Medical Record and the
Medical Journal of South Africa

Registered at the General Post Office as a newspaper

By die poswese as nuusblad geregistreer

Cape Town, 17 July 1954
Weekly 2s. 6d.

Vol. 28 No. 29

Kaapstad, 17 Julie 1954
Weekliks 2s. 6d.

IN THIS ISSUE: IN HIERDIE UITGAWE

Editorial: Van die Redaksie

The Coming Referendum
Die Aanstaande Referendum

Sub Editorial:

The Laboratory Control of Tuberculous Meningitis

Original Articles: Oorspronklike Artikels

Human Plasma for Transfusion — Factors Governing the
Preparation of a Safe Product

The Domiciliary Care of Sick Persons as Part of a Comprehensive
Health and Medical Care Programme

Special Sub-Committee to Enquire Into the Registration of Specialists: Spesiale Subkomitee
om Ondersoek in te Stel na die Registrasie van Spesialiste.

Association News: Verenigingsnuus

National General Practitioners Group (Amended Constitution)

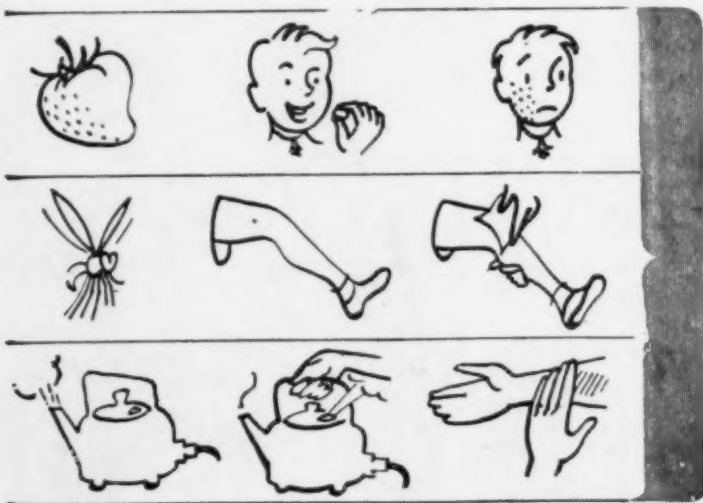
Passing Events: In die Verbygaan

Correspondence: Briewerubriek

Reviews of Books: Boekresensies

Support Your Own Agency Department
Ondersteun u Eie Agentskap-Afdeling
Professional Appointments
Professionele Betrekkings

(P. xxxvi)
(B. xxxvi)
(Pp. xxxvi-xxxviii)
(B. xxxvi-xxxviii)



MA.1267

LOCAL RELIEF WITH 'ANTHISAN' CREAM

trade mark
MEPYRAMINE MALEATE

OR

'PHENERGAN' CREAM WITH DIBROMOPROPAMIDINE

*N.B. 'Phenergan' Cream is now an antiseptic
as well as an antihistaminic cream.

Supplied in Tubes of 1 oz. and containers of 1 lb.

Manufactured by MAY & BAKER LTD

Distributors
MAYBAKER (S.A.) (PTY.) LTD
P.O. BOX 113 PORT ELIZABETH



The Non-habit forming Antispasmodic

with the
COMBINED ACTION
of
ATROPINE and PAPAVERINE
NO SIDE EFFECTS

AVACAN

TABLETS 50 mgm

AMPOULES 1 cc (25 mgm)

Spasms of smooth muscle :-

Coronary vessels, bronchi, alimentary tract, bile-duct,
urinary tract, genital organs.

Essential hypertension, migraine, neurovegetative dystonia.

Under the formula of Asta-Werke AG, Brackwede-Germany.

Manufactured in South Africa by

NORISTAN LABORATORIES (PTY.) LTD — SILVERTON/PRETORIA



DISPRIN

REGD.

*— Soluble, substantially neutral and palatable
aspirin tablets in stable tablet form*

Great difficulty has hitherto been encountered in providing soluble aspirin in tablet form which will remain stable under ordinary condition of storage. This difficulty has now been overcome.

Disprin has all the valuable qualities of calcium aspirin—analgesic, antipyretic and anti-rheumatic. Since it is soluble, it is more rapidly absorbed and consequently more speedy in its clinical effect. Moreover, it is unlikely to irritate the gastric mucosa.

Disprin tablets readily dissolve in water to form a substantially neutral palatable solution of calcium aspirin.



Made by the manufacturers of "D-nal"

Clinical samples and literature supplied on application.
Special hospital pack — prices on application.

RECKITT AND COLMAN (AFRICA) LTD., P.O. BOX 1097, CAPE TOWN

MS/HP

Stop bleeding

from broad capillary bed . . .

Adrenosem (adrenochrome semicarbazone sodium salicylate), a synthetic complex, is a unique systemic hemostat, administered orally or parenterally.

It will not raise blood pressure nor affect cardiac rate or volume. It does not affect blood components associated with clot formation.

Adrenosem has such a high index of therapeutic safety that there are no contraindications in the recommended dose. Case histories attest its value as a hemostat in surgery and in pathologies characterized by hemorrhagic tendencies.*

*Sherber, D. Am. J. Surg., Sept. 1953

U. S. Pat. 2,581,850-1952

Adrenosem

send for
professional
literature

Massengill

BRISTOL, TENN.

indicated in

Idiopathic purpura
Prostatic surgery

Retinal Hemorrhage

Nasopharynx surgery

Familial telangiectasia

Postoperative
Bladder surgery

Tonsillectomy

Hemoptysis

Epistaxis

Westdene Products (Pty.) Ltd.

22-24 Essanby House
P.O. Box 7710

175 Jeppe Street

JOHANNESBURG
Phone 23-0314

CAPE TOWN: 211 CTC Buildings, Corporation Street - - - - - Phone 2-2276

PRETORIA: 222 Central House, Central Street - - - - - Phone 3-3487

DURBAN: 66/67 National Mutual Buildings, Corner Smith and Gardiner Streets Phone 2-4975

Nulacin

CLINICAL STUDIES IN THREE CONTINENTS

CLINICAL STUDIES on the use of NULACIN tablets in the control of gastric acidity were reported in 1952.*

Now, further clinical studies, recently published in Australia, the United States, and Great Britain,† confirm the value of NULACIN.

INDICATIONS

NULACIN tablets are indicated whenever neutralization of the gastric contents is required:—in active and quiescent peptic ulcer, gastritis, gastric hyperacidity.

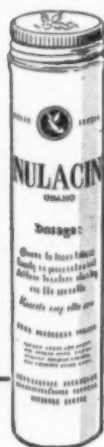
NULACIN provides control of gastric acidity comparable with that obtained with intragastric milk-alkali drip therapy and is a most convenient and effective form of treatment for bed and ambulatory patients.

DOSAGE: Beginning half-an-hour after food, a NULACIN tablet should be placed in the mouth and allowed to dissolve slowly.

During the stage of ulcer activity, up to three tablets an hour may be required. For follow-up treatment, the suggested dosage is one or two tablets between meals.

NULACIN tablets are not advertised to the public and have no B.P. equivalent. NULACIN tablets are made by Horlicks Limited, Slough, England, and supplies are freely available through all wholesalers and retail chemists in South Africa and Rhodesia.

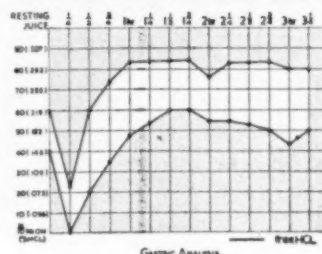
NULACIN tablets are prepared from whole milk combined with dextrans and maltose, and incorporate Magnesium Trisilicate 3.5 grs.; Magnesium Oxide 2.0 grs.; Calcium Carbonate 2.0 grs.; Magnesium Carbonate 0.5 grs.; Oil Menth. Pip. q. s.



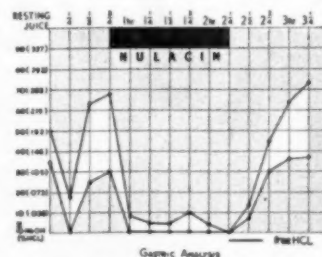
REFERENCES:

- *The Control of Gastric Acidity, Brit. Med. J., 180-182, 26th July, 1952.
- *Medical Treatment of Peptic Ulcer, Med. Press, 195-197, 27th February, 1952.
- †The Effect on Gastric Acidity of "Nulacin" Tablets, Med. J. Aust., 823-824, 28th November, 1953.
- †Control of Gastric Acidity by a New Way of Antacid Administration, J. Lab. Clin. Med., 42-955 (1953).
- †Further Studies on the Reduction of Gastric Acidity, Brit. Med. J., 183-184, 23rd January, 1954.

Sole South African distributors,
Professional Pharmaceuticals Limited,
P.O. 2515 Johannesburg.
Sole Rhodesian distributors,
R. F. Oakley & Company (Pvt.) Limited,
7 Gordon Avenue, Salisbury.



Superimposed gruel fractional test-meal curves of five cases of duodenal ulcer



Same patients as in Fig. 1, two days later, showing the striking neutralizing effect of sucking Nulacin tablets (3 an hour). Note the return of acidity when Nulacin is discontinued.

HORLICKS LIMITED, Pharmaceutical Division, Slough, Bucks.

South African Medical Journal
Suid-Afrikaanse Tydskrif vir Geneeskunde
P.O. Box 643, Cape Town Posbus 643, Kaapstad

Cape Town, 17 July 1954
Weekly 2s. 6d.

Vol. 28 No. 29

Kaapstad, 17 Julie 1954
Weekliks 2s. 6d.

CONTENTS — INHOUD

Human Plasma for Transfusion — Factors Governing the Preparation of a safe product, Maurice Shapiro	601	The Domiciliary Care of Sick Persons as Part of a Comprehensive Health and Medical Care Programme, H. T. Phillips, M.B., Ch.B., D.P.H. and Helen D. Cohn, R.N., R.M., M.P.H.	613
Editorial: The Coming Referendum	605	Association News: Verenigingsnuus	604
Van die Redaksie: Die Aanstaande Referendum	605	National General Practitioners' Group (Amended Constitution)	617
Sub-Editorial: The Laboratory Control of Tuberculous Meningitis	606	Passing Events: In die Verbygaan	617
Special Sub Committee to Enquire into the Registration of Specialists		Reviews of Books: Boekresensies	618
Memorandum: Spesiale Subkomitee om Ondersoek in te Stel na die Registrasie van Spesialiste: Memorandum	607	Correspondence: Briewerubriek	619

'Round the Clock



Blades ... 3/9. pkt. of six

B-P RIB-BACKS make it Easy

Stocked by all reliable
Surgical Instrument Depots



Easy ON THE SURGEON because he is assured dependable blade performance by uniform sharpness—greater strength and rigidity.

Easy ON THE ASSISTANTS because dependable blade performance reduces time consuming delays detrimental to clocklike surgical procedure for the entire surgical team.

Easy ON THE BUDGET because the purchaser of B-P RIB-BACKS is assured proved cutting performance from every blade—and the maximum of satisfactory service ... thus reducing blade consumption to an economic minimum.

GURR SURGICAL INSTRUMENTS (PTY.) LTD.

Harley Chambers Kruis Street
Johannesburg P.O. Box 1562

Please Support Our Advertisers — Ondersteun Asseblief Ons Adverteerders

MINNITT GAS-AIR ANALGESIA APPARATUS IMPROVED HOSPITAL MODEL

The Improved Minnitt Gas-Air Apparatus Hospital Model is encased in an attractive cabinet that is mounted on Castors. It accommodates two 200-gallon Nitrous Oxide side outlet cylinders.

This apparatus is designed to conform to the specifications stipulated by the Central Midwives' Board, England, which specifies that such apparatus must be capable of delivering a 45% Nitrous Oxide in 55% air mixture.

The apparatus is for self administration and is of the intermittent flow type, thus preventing the loss of gas when the face-piece is laid aside during administration. As a safety precaution against the state of anaesthesia being reached, the angled expiratory mount which connects the face-piece to the corrugated tubing has a hole opposite the face-piece inlet. During administration the patient covers this hole with the index finger and should the mixture carry the patient through to anaesthesia the finger will fail to keep this hole properly closed, thus allowing air to be inhaled.

The apparatus is, also, often required by doctors for administering more concentrated and rapid acting analgesia, therefore an accessory for this apparatus known as the C.M. Attachment is available at a small additional cost. It should be noted that when a C.M. Attachment is used the apparatus ceases to conform with C.M.B. specifications. Provided this attachment is plugged into the apparatus 2½ minutes before required, the initial few breaths taken will be at 100% Nitrous Oxide concentration. This will induce a rapid analgesia. Once the 2½-litre bag has been depleted the 45%-55% mixture augmented by a slight trickle of Nitrous Oxide is administered for maintenance of analgesia.

Further details concerning this and all other medical apparatus supplied by Messrs. African Oxygen & Acetylene (Pty.) Ltd., will be given gladly on request.



AFRICAN OXYGEN & ACETYLENE (PTY.) LTD.

MEDICAL DEPARTMENT

MEDICAL SHOWROOM: 76, King George Street, Hillbrow, Johannesburg.

Phone: 44-4998.

Head Office:

AFROX HOUSE, Cor. Booysens Road and Webber Street, Johannesburg.

Branches throughout the Union, Rhodesias, East Africa and South West Africa.



The combined sedative action of Bromoform and Codeine, together with extracts of Senega, Krameria and Wild Cherry, give relief both to congestion and rawness in the chest. Control and limitation is the purpose of this preparation which is pleasant to take and suitable for patients of all ages.

Specimen and literature on request.

P.O. Box 1573, JOHANNESBURG.

CROOKES BROMOFORM CO



THE CROOKES LABORATORIES LIMITED • PARK ROYAL • LONDON • N.W.10

FERROSAN

of
COPENHAGEN

INTRODUCE TO THE SOUTH AFRICAN
MARKET THEIR

VITAMIN B COMPLEX INJECTION

OF HIGH POTENCY AND AT A REASONABLE PRICE

DOCTOR'S PRICE 6/9 ea.

Sole Distributors:

B. OWEN JONES, LTD.

P.O. Box 8127

P.O. Box 36

P.O. Box 679

P.O. Box 434

JOHANNESBURG

BOKSBURG

EAST LONDON

CAPE TOWN

BECOPLEX

injectable


10 c.c. rubber capped vial.

Each c.c. contains:

Thiamin Cl	15 mgm.
Riboflavin	2 mgm.
Pyridoxin Cl	4 mgm.
Niacinamide	50 mgm.

together with all other Vitamins of B. Complex derived from 2 gm. of fresh liver including Folic Acid, Biotin, Cholin and Para-Aminobenzoic Acid.





a surgical problem...

The patient often judges the skill of the surgeon by the degree of scarring, particularly in operations of the face, neck, breasts, hands or extremities.

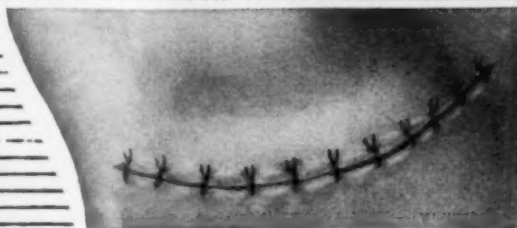
a product...

D & G Product No. 1682, Dermalon, provides minimal skin closure scarring.

a name...

Davis & Geck, Inc. created this product to solve a specific problem. The same care and precision is given each of the more than 300 needle-suture combinations designed for each surgical need.

D & G Product
No. 1682, Dermalon
monofilament
nylon suture with
Atraumatic needle
CE-4 cutting point
shown actual size.



Request Complete Catalog



Davis & Geck, Inc.

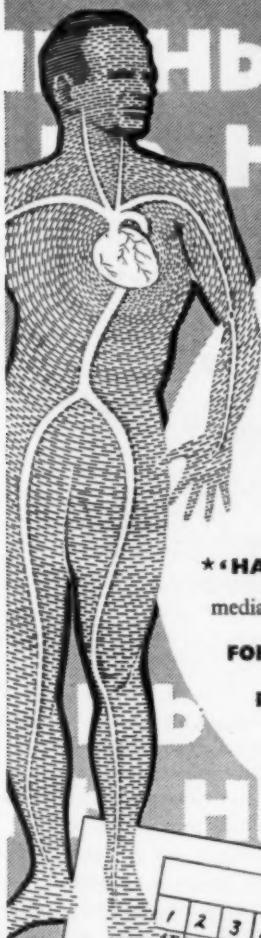
A UNIT OF AMERICAN *Cyanamid* COMPANY

1 Casper Street, Danbury, Conn., U.S.A.

Distributors:
M. Stabler, Esq.,
M.P.S., Chas. F.
Thackray (S.A.)
(Pty) Ltd., P.O. Box
2726, Johannesburg
and P.O. Box 816,
Cape Town.



НБ НБ НБ НБ НБ FIRST in SECONDARY ANAEMIAS **HAEMATOGEN** HOMMEL НБ НБ НБ НБ НБ



In microcytic anaemias — chlorotic, postoperative, haemorrhagic — the therapeutic aim is to increase the number and haemoglobin value of the erythrocytes.

For rapid haematinic effect, 'Haematogen'-Hommel, produced by refinement of actual whole blood and comprising haemoglobin, albumin and iron, is a rational replacement therapy in the above-mentioned blood deficiency states. It is also valuable in correction of mal- or sub-nutrition and in convalescence.

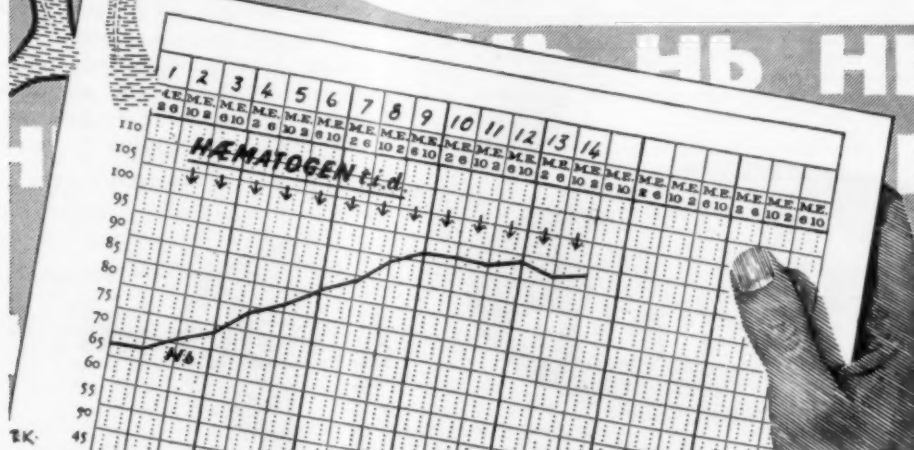
★ **'HAEMATOGEN'**-Hommel is presented in semi-fluid form, for immediate and acceptable administration to children and adults.

FORMULA — Active constituents: *Haemoglobin 17.5%, Albumin 7.5%.*

PACKING — Bottles of 8 fluid ounces.

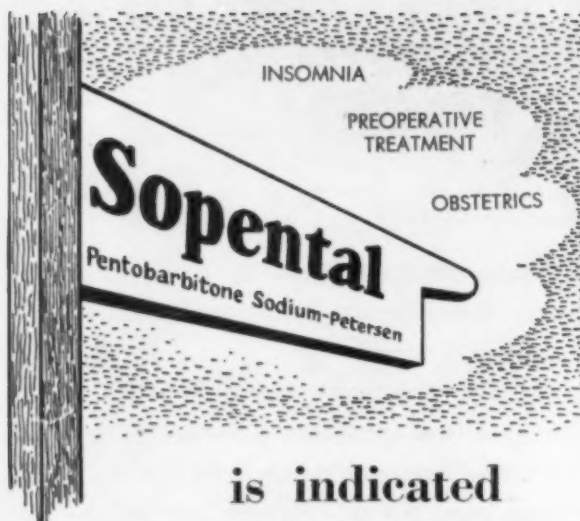
HOMMEL'S HAEMATOGEN & DRUG CO.

121 NORWOOD ROAD, LONDON S.E.24



Our Sole Agents for SOUTH AFRICA :— Messrs. LENNON LIMITED

P.O. Box 39. CAPE TOWN • P.O. Box 24. PORT ELIZABETH • P.O. Box 266. DURBAN, NATAL
 P.O. Box 928. JOHANNESBURG, TRANSVAAL • P.O. Box 76. EAST LONDON
 P.O. Box 1102. BULAWAYO, Southern Rhodesia • P.O. Box 379. SALISBURY, Southern Rhodesia



INSOMNIA
PREOPERATIVE
TREATMENT
OBSTETRICS

Sopental
Pentobarbitone Sodium-Petersen

is indicated

SOPENTAL is the mono-sodium derivative of 5-ethyl-5-(1-methylbutyl)-barbituric acid.

ACTION AND USES: SOPENTAL is one of the more rapidly acting barbiturates, but its duration of action is short.

INSOMNIA. In those cases of insomnia where the patient experiences difficulty in getting off to sleep, SOPENTAL has an advantage over other barbiturates, since its short action is less likely to leave the patient in a state of depression during the morning following administration. The normal dosage employed is one or two tablets (in the average patient one tablet is sufficient) immediately before retiring.

PREOPERATIVE TREATMENT. SOPENTAL may be used as a basal anaesthetic prior to surgical operation, its sedative effect minimising the amount of general anaesthetic required. In these cases the normal procedure is one tablet the evening before operation, a further tablet two hours before, and, if necessary, a third tablet one hour before operation.

OBSTETRICS. SOPENTAL may be employed for the production of obstetrical amnesia, where the optimum dose is that which reduces pain without depressing uterine contractions. Here it is usual to start with one tablet at the commencement of labour, repeating the dose, when necessary, up to a maximum of five tablets.

SOPENTAL is almost completely destroyed by the liver, and is therefore useful in cases of impaired renal function.

SOPENTAL is issued as tablets of Pentobarbitone Sodium 1½ grains in each, in bottles of 40 and 500.

Manufactured in South Africa by



Established 1942

CAPE TOWN	DURBAN	SALISBURY	JOHANNESBURG
P.O. Box 38	113, Umbilo Road	P.O. Box 2238	P.O. Box 5785

A NEW COMBINATION

CODIS

**soluble aspirin with
codeine phosphate
and phenacetin**

Codis presents a familiar grouping of analgesic drugs; aspirin, phenacetin, codeine phosphate; with an important advantage. The "aspirin" in Codis is rendered soluble as in "Disprin".

Placed, uncrushed, in water, a Codis tablet disperses in a matter of seconds to form a solution of calcium aspirin and codeine phosphate with finely suspended phenacetin. The chance of irritation of the gastric mucosa by undissolved particles of aspirin is thus minimised.

Codis is recommended for all those conditions for which Tab. Codein. Co. B.P. would be prescribed. It has the added advantages of greater ease of administration and far less likelihood of aspirin intolerance, while the rapid absorption of the soluble aspirin promotes prompt relief. Codis is not advertised to the public.



COMPOSITION:

Each Codis tablet contains: Acid Acetylsalicyl. B.P. 4 grs., Phenacet. B.P. 4 grs., Codeine Phosph. B.P. 0.125 grs., Calc. Carb. B.P. 1.2 grs., Acid. Cit. B.P. (Exsic) 0.4 grs., Excip. ad. 11.45 grs.

BECKITT & COLMAN (AFRICA) LTD., P.O. BOX 1097, CAPE TOWN

*In atrophic and senile vaginitis
and postmenopausal
pruritis vulvae*



Dienoestrol Cream (Ortho) combats painful and distressing symptoms associated with atrophy of the vaginal epithelium — pruritis, inflammation, pelvic discomfort and discharge — by stimulating the vaginal mucosa to a more normal state.

**high concentration
at the point of need**

Locally applied, Dienoestrol Cream is logical, effective therapy in senile and atrophic vaginitis

low incidence of side effects

Even in patients using Dienoestrol Cream (Ortho) for as long as 12 months, no complications have been noted.*

*Am. J. Obs. & Gynec. 57 : 1018, 1949

Dosage: One applicatorful per day for one or two weeks, reduced to one applicatorful every 48 hours for a similar period.

On original prescriptions specify "Dienoestrol Cream (Ortho) with applicator."

Literature and Sample on request.

Ortho Pharmaceutical Limited

ENGLAND

Makers of Gynaecic Pharmaceuticals



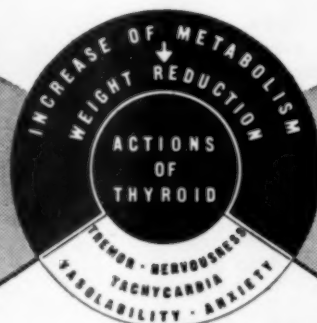
widely indicated...

Sole Distributors: ETHICAL PRODUCTS (PTY.) LTD.
(Ethical Division Johnson & Johnson (Pty.) Ltd.), P.O. Box 727, East London.

wisely prescribed

APONDON

PHARMACOLOGICALLY
**DETOXIFIED
THYROID**
FOR THE TREATMENT OF
**OBESITY
MYXŒDEMA**
AND
**ALLIED ENDOCRINE
DYSFUNCTIONS**



These side effects do NOT arise with APONDON

APONDON treatment does not interfere with sleep or normal daily activities

Bottles of 25 and 500 pills

For further information and samples apply to our Agents:
LENNON LIMITED, P.O. Box 8389, JOHANNESBURG

VERITAS DRUG COMPANY LIMITED
LONDON AND SHREWSBURY, ENGLAND



Made in England

South African Trade Representatives: Gurr Surgical Instruments Pty. Ltd., Harley Chambers, Kruis Street, Johannesburg

THIS DIAGNOSTIC SET for the examination of Ear, Eye, Nose and Throat, incorporates all possible improvements which have come to light during the past 20 years.

All the bright parts are finished in untarnishable chromium plate of super-excellent quality. Non-ferrous and entirely rustless alloys are used throughout, and the heavier parts, such as the Battery Handle, are made of light alloy. Housed in a handsome hard-wearing box, fitted with a newly designed catch, the instruments will always be ready for instant use and prove to have a remarkably long and trouble-free life.

CONTENTS

Improved May Ophthalmoscope
Auriscopes with 3 interchangeable specula
Throat Lamp
1 each Laryngeal and Post Nasal Mirror
Tongue Depressor
Large Battery Handle and Spare Lamp
Complete in case Cat. No. 3004

Gowland
electric diagnostic instruments

clinical efficiency

The germicidal efficiency of 'Dettol' remains high even in the presence of blood, pus and wound debris. This property, coupled with its wide margin of safety, makes 'Dettol' invaluable for use in emergencies, not only by you, but in the less qualified hands of others who in emergency might have to render first aid.

DETTOL

THE MODERN ANTISEPTIC

RECKITT & COLMAN (AFRICA) LTD., P.O. BOX 1097, CAPE TOWN

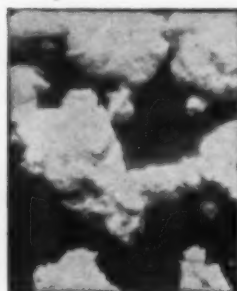
THE *curd* PROBLEM

IN CONVALESCENT DIET...

Milk is an ideal source of protein but frequently the convalescent is intolerant to the normal formation of curds in the stomach so that intake is reduced, digestion impaired and absorption of protein diminished.

This problem is solved when milk is partially pre-digested with Benger's Food. Extremely fine curd formation is thus ensured resulting in improved tolerance and intake with maximal protein absorption.

The photomicrographs show the effect of gastric juice on both milk and Benger's Food and indicate the type of curd produced. Benger's Food may be recommended with confidence.



Pasturised Milk



Bailed Milk



Benger's Food —
pre-digested for
5 minutes



Benger's Food —
pre-digested for
15 minutes

BENGER'S FOOD

South African Medical Journal Suid-Afrikaanse Tydskrif vir Geneeskunde

P.O. Box 643, Cape Town

Posbus 643, Kaapstad

Cape Town, 17 July 1954
Weekly 2s. 6d.

Vol. 28 No. 29

Kaapstad, 17 Julie 1954
Weekliks 2s. 6d.

HUMAN PLASMA FOR TRANSFUSION— FACTORS GOVERNING THE PREPARATION OF A SAFE PRODUCT

MAURICE SHAPIRO

The South African Blood Transfusion Service Johannesburg

Human plasma is indicated as the transfusion fluid of choice in all those conditions in which the clinical response depends on the fluids and solutes rather than the cellular elements of whole blood.¹ In hypoprothrombinaemia, haemophilia and thrombocytopenic purpura, fresh plasma is at least as effective as whole blood in correcting the disorder of the clotting mechanism. For the emergency treatment of shock, whether associated with haemorrhage or not, plasma will restore effective blood volume as efficiently as whole blood although it will not, of course, correct the anaemia which may have resulted from the loss of red cells. In hypoproteinaemic states such as those associated with severe nitrogen losses (e.g. serious injury or surgical operation, sepsis, nephrosis, burns, repeated paracentesis), with deficient absorption of proteins (e.g. diarrhoea and vomiting in infants and intestinal carcinoma in adults), or with impaired synthesis of blood proteins (as in liver diseases), transfusions of plasma, supplemented when necessary by whole blood, may be essential adjuvants to successful therapy.

There is a number of practical difficulties in preparing plasma on a scale sufficient to meet the needs and in a form which can be pronounced entirely safe for intravenous use. Human plasma and serum as currently prepared in many parts of the world carry a high risk of infection with the virus of homologous serum jaundice and a high rate of reactions from pyrogens, toxic products of bacterial contamination and anaphylotoxins. It is undoubtedly because of the tardy recognition of these hazards and of the elaboration of effective measures of eliminating them that there has recently been an increasing tendency to employ plasma substitutes in the form of dextran, polyvinyl pyrrolidone and refined gelatin. However, no-one has ever claimed that these macro-molecular substances are equivalent to human plasma. In order to indicate their proper sphere of

therapeutic application, most responsible authors have preferred to designate them as 'plasma volume expanders' whose main, if not sole, use in clinical practice is as an emergency fluid in the treatment of shock. Even this restricted claim would appear to be based on the assumption that shock is merely a disturbance of the physical dynamics of the circulation with a consequent temporary deficit in effective circulating blood volume. This is an over-simplification of the true position; it ignores the profound disturbances of physiology and chemistry affecting the entire being, for the effective correction of which blood-proteins, electrolytes, etc., may be essential.^{2a}

Three main considerations are involved in the preparation of safe plasma:

1. Avoidance of immediate untoward reactions, particularly those which may be attributable to pyrogenic and toxic products from microbial contamination.
2. Elimination of the risk of widespread transmission of the virus of homologous serum jaundice.
3. Realistic assessment of the risk associated with the infusion of incompatible iso-agglutinins and the application of appropriate safeguards.

MAINTENANCE OF STERILITY AND APYROGENICITY

Despite the most rigid precautions in the collection of human blood for transfusion, contamination with small numbers of micro-organisms—bacteria and moulds—occurs inevitably in a small proportion of cases.³ These may be introduced from the air, from the hands of the operator or from the donor's skin during venipuncture. During World War II it was demonstrated that in British blood banks⁴ an average of 5% of all blood collected was contaminated. Reissmann⁵ recorded a contamination rate of 6% in winter and 10% in summer. Fortunately, the growth

of most organisms is inhibited in whole blood, particularly if it is stored at 4° to 6° C, and such blood can generally be given without noticeable disturbance or with only a mild febrile reaction. On rare occasions, violent and even fatal reactions may follow contamination with *Pseudomonas pyocyanea* and aerial coliform-organisms which may produce profuse growth within a few hours after removal of the blood from the refrigerator. With the recent advances in blood-grouping and cross-matching techniques, contaminated blood probably presents a greater transfusion hazard today than does serological incompatibility. The use of open containers for blood collection increases the risks from air-borne contaminants enormously. A closed system of bleeding into vacuum flasks containing sterile, apyrogenic, anticoagulant solution, rigid precautions in the preparation of the donor's skin, a 'non-touch' technique in the performance of the venipuncture, and the use of sterile, apyrogenic bleeding equipment, should be mandatory in the collection of blood.

In 8,467 bottles of blood obtained at fixed bleeding-centres and with mobile units from 22 branches and depots of the South African Blood Transfusion Service during the summer months of September 1953 to March 1954, positive bacteriological cultures were obtained in 254 (3%). These bloods had been collected 2-16 days before testing. Of the 254, 97 cultures contained cocci (streptococci 15 and staphylococci 82), 121 contained bacilli (mostly gram-negative) and 36 contained moulds (spores 11 and fungi 25). These results compare favourably with those of other investigators. It is significant that during the corresponding period the total recorded reactions from transfusions was less than 1% (including febrile, allergic and other reactions).

Although these facts demonstrate that minimal contamination is not uncommon and is unlikely to lead to any harmful effects in whole-blood transfusions, they also serve to show that in pooling plasma from large numbers of donors contamination of the pool is highly probable, if not inevitable. Plasma is itself a good culture-medium and the measures which are customarily adopted to obviate gross contamination of the pools are: (1) The addition of antiseptics such as merthiolate and phenyl mercuric borate; and (2) Filtration.

Antiseptics in concentrations sufficient to sterilize or inhibit growth effectively may themselves be toxic, particularly if given in large doses, as may occur in multiple or massive transfusions of plasma. Bacterial filtration of citrated plasma is difficult and unsatisfactory owing to clotting from fibrin. Attempts have been made to precipitate the fibrin with kaolin before filtration. This converts the plasma to serum, which filters easily.⁶ However, it is difficult if not impossible to prepare kaolin in an entirely non-pyrogenic state. Further, it is apparent that neither antiseptics nor filtration will eliminate toxins already elaborated by contaminating organisms.

The routine adopted in our laboratories in the preparation of sterile dried plasma is as follows:

1. No preservatives are added.
2. Pooling is avoided. Approximately 275 c.c. of citrated plasma is derived from one donor. This is the average yield from 500 c.c. of whole blood with 75 c.c. A.C.D. solution added.

3. Each unit of blood is bacteriologically controlled in fluid thioglycollate medium at the time of aspiration of the plasma. Reliance cannot be placed solely on the macroscopic appearance of the cultures. Therefore, after 7 days incubation, samples of all cultures are aspirated and centrifuged for 1 hour, and the sediment stained and examined microscopically. If organisms are present, repeat cultures of the liquid plasma are taken on agar plates and in fluid thioglycollate medium.

4. Sterile disposable vacuum bottles are employed for aspiration of the plasma from the blood bottle. A closed system is therefore maintained as in the bleeding of donors.

5. The bottles of liquid plasma are stored for a minimum period of 6 weeks at room temperature to permit growth of any organisms which may have been present in minimal numbers and so escaped detection in the initial control.

6. At the expiration of this period, each bottle is re-controlled as under (2). If any fibrin has settled out of the plasma during storage (this rarely occurs to any considerable extent under 3 months), the clear plasma is re-aspirated into a fresh vacuum bottle. If the content of liquid plasma in the bottle is below 275 c.c., it is topped up to this level with plasma from another bottle. Thus each unit of the dried product consists of the plasma from one, or occasionally from two donors.

7. Immediately after taking the re-controls referred to in (5), the plasma is spun frozen and stored for 7 days at -25°C. If the final cultures prove sterile, the rubber bungs are removed from the frozen plasma bottles, and the mouths of the bottles covered with 8 layers of sterile gauze. The bottles are then placed in the primary chamber of an Edward's Vacuum Drying plant. When the plasma is dry (i.e. after about 24 hours) the bottles are transferred to the secondary high-vacuum chamber for 18-24 hours, where the residual moisture is reduced to less than 1% dry weight. The secondary chamber is then filled with dry nitrogen and the bottles removed for final capping. This consists of the introduction of a tightly-fitting rubber bung incorporating a built-in air-inlet tube (as in the Baxter Haemovac). The rubber bung is forced in after drawing a vacuum in the bottle.

8. The dried plasma is dispensed with a separate bottle containing 300 c.c. sterile, apyrogenic, 1% citric-acid solution, and an apyrogenic giving set incorporating a blood filter and a double-ended needle for transferring the solvent to the plasma bottle.

The above routine is costly and laborious and differs in several important respects from the methods ordinarily employed in the preparation of pooled plasma. However, the additional effort and expense would appear to be warranted, as shown by the fact that during the past year only 2 reactions (both febrile) have been reported from 2,500 units given. The great merit of dried plasma is that the growth of bacteria is impossible in this state. Maximum assurance of complete sterility of the product can be given because possible contaminants have been allowed adequate opportunity to flourish in the liquid plasma, and bacteriological re-controls taken immediately before freeze-drying have proved negative. Because the plasma is unpooled, unfiltered and obtained from

non-fasting donors, there is an inevitable variation in the appearance of different bottles of reconstituted plasma. In addition, a certain degree of breakdown of the lipo-proteins takes place during drying, with the result that the reconstituted plasma is, in any case, always somewhat more cloudy than the original liquid plasma. Although the therapeutic value of the plasma is in no way impaired thereby, the lack of uniformity in colour and clarity is a disadvantage. In the hands of practitioners unfamiliar with the product, slight greenish or greyish discolouration (due to small amounts of methaemoglobin) or turbidity (due to lipids) have, on occasions, erroneously been attributed to contamination. In order to obviate the risk of small emboli due to particles of fibrin, reconstituted plasma must, of course, always be administered through a blood filter.

THE AVOIDANCE OF VIRUS CONTAMINATION

The transmission of homologous serum jaundice has proved to be by far the greatest hazard involved in plasma transfusion. During World War II the attack rate among recipients of lyophilised plasma from pools contaminated with the virus ranged between 5% and 22%.⁷ As a consequence, large residual stocks of plasma in the United States were withdrawn from circulation. It was claimed that exposure to ultra-violet rays before freeze-drying would destroy the icterogenic agent, and this procedure was adopted routinely by most commercial producers. At the outbreak of the Korean War, large quantities of this stockpiled plasma were reconstituted with water, pooled into larger pools, irradiated and re-dried. In due course 22% of all recipients of plasma in Korea contracted homologous serum jaundice. In 1950, Garrott Allen and co-workers⁸ first suggested that the virus of homologous serum jaundice, which is apparently preserved indefinitely in the dried or frozen state, becomes non-pathogenic or 'dies' in pooled plasma stored at room temperature for 6 months or longer. They have recently produced strong evidence in support of this claim.⁹ Murray and his co-workers¹⁰ inoculated human volunteers with plasma from donors suffering from homologous serum jaundice at the time that their blood was drawn. For the freshly-prepared pool, the attack rate was 52% but after 6 months storage at room temperature only 1 of 20 volunteers given the plasma contracted the disease and this was in a very mild form.

Another and more obvious way of preventing the widespread virus infection of recipients of plasma is, of course, to avoid pooling and to exclude as blood donors all persons with a previous history of jaundice. During the past 4 years we have processed plasma on a unit for unit basis. Until a year ago most of this plasma was stored in the frozen state. A small number of units of very clear plasma was dispensed in the liquid state. During the past year all plasma has been dried in accordance with the routine described above, except for such small supplies of frozen fresh plasma as are occasionally required for their content of labile elements—prothrombin, complement, etc. During these 4 years not a single case of jaundice attributable to transfused plasma has been reported to us. A proportion of the stocks at present

being dried has been stored at room temperature for 6 months to 2 years.

It is our impression that the longer plasma has been preserved in the liquid state before drying the less likely it is to cause any febrile or allergic reaction. Provided that the plasma is sterile, storage in the liquid state at room temperature for 2 years or longer has been shown not to impair its therapeutic value in any way.¹¹ In the dried state, plasma can probably be preserved indefinitely.

THE QUESTION OF INCOMPATIBLE ISO-AGGLUTININS

Pooled plasma prepared from unselected donors contains iso-agglutinins anti-A and anti-B. Theoretically, these iso-agglutinins can produce agglutination and haemolysis *in vivo* of the cells of recipients of all groups other than O. Extensive experience has demonstrated that haemolytic reactions from this cause rarely, if ever, occur.^{12, 13} In pooled plasma, partial reciprocal inactivation of anti-A and anti-B iso-agglutinins takes place, due to dissolved A and B substances.¹⁴ On theoretical grounds, this is the only purpose of pooling. The question therefore arises whether iso-agglutinins in unpooled plasma can be given with equal safety. Thalheimer¹⁵ is of opinion that plasma with agglutinin titres of 1 : 512 or less can be given safely, regardless of the type of the recipient. White and Wainstein^{2b} state: 'We have never observed an agglutinating reaction with the injection of untyped and unpooled plasma during a 7-year period of study'. These authors did not select the donors of the plasma according to iso-agglutinin titre.

In the transfusion of fresh Group-O blood (which contains both anti-A and anti-B agglutinins and may also contain haemolysins) to recipients of other groups, the risks involved are theoretically greater than in the use of pooled plasma. Our own extensive experience with the use of Group O blood as 'universal donor' blood is therefore relevant:

Since the inception of the South African Blood Transfusion Service in 1937 it has been our consistent policy to stock only Group-O blood in all depots and branches of the Service except those in which trained technicians are constantly available to perform the cross-matching tests. In view of the potential hazards of haemolytic reaction from destruction of the recipient's cells by high-titred immune antibodies in the donor's plasma, all O, A and B donors in the Service have for many years been screened according to their titre of iso-agglutinins. O, A and B donors with iso-agglutinin titres in excess of 1 : 250 are labelled 'high-titred', and their bloods are used exclusively as whole blood for recipients of the same blood-group. 'Low-titred' Group-O blood is regarded as 'universal donor' blood and in our smaller branches and depots no other than this is supplied. This policy is based on the conviction that the risk to the patient from clerical and technical errors (such as may arise even in a highly-organized blood bank) and inexperience on the part of practitioners, who may be called upon infrequently to group and cross-match blood for their own patients, far outweigh the theoretical risks of minor incompatibility in the exclusive use of Group-O low-titred blood. Although mishaps

have occurred owing to occasional neglect of Rh typing of patients before transfusion, not a single case of haemolytic reaction attributable to transfusion of incompatible iso-agglutinins has been recorded by us in over 100,000 Group-O transfusions given in our smaller branches and depots to all patients regardless of their blood groups. Our own experience in this connection has recently received striking confirmation from the report by Crosby and Akeroyd¹⁶ on transfusion practice during the Korean War. Only Group O, Rh positive, low-titred blood was sent to the combat areas in Korea and this blood was given without preliminary cross-matching to all casualties irrespective of their blood-groups, sometimes in enormous quantities. In cases of severely wounded men it was not uncommon to give 10, 20 or even 30 pints of blood within a few hours. No haemolytic reactions attributable to iso-haemagglutinins were observed in over 60,000 transfusions given in Korea in 1952. The authors investigated the effects of some of these massive transfusions in an endeavour to ascertain if less severe reactions occurred on the basis of incompatibility on the minor side. They found that in some cases transfused iso-agglutinins could be detected by *in vitro* tests in the cold and that these might persist for several days after transfusion, with selective destruction of the patient's own cells. This was particularly likely to occur in Group-A patients who were non-secretors or weak secretors of Group-A substance. However, the resulting haemolysis did not cause haemoglobinuria, threaten life or impede recovery in any of these patients. Anti-B agglutinins in Group-O low-titred blood appeared to cause little or no haemolysis in Group-B patients.

Reverting to the practice in the South African Blood Transfusion Service, the policy of using only low-titred Group-O blood for whole-blood transfusions in our smaller branches and depots results in a relative surplus of bloods of other groups. All high-titred and some low-titred Group-A and Group-B bloods are diverted to the larger branches for homologous group transfusions so that about 50% of low-titred A and B bloods, some AB bloods and a few O bloods become available for plasma production. AB blood contains no iso-agglutinins. In view of the frequent and relatively large transfusions of plasma which may be required in the treatment of seriously sick babies suffering from vomiting, diarrhoea and malnutrition, it is our practice to reserve AB plasma for use in infants only. Of Whites 45% and of Africans 49% are Group O. No minor incompatibility is created by giving them plasma which contains either anti-A or anti-B agglutinins, since their bloods normally contain both. A further 40% of Whites

and 30% of Africans are Group A. Here again, no incompatibility is created if Group-A plasma is given. Because of the virtual exclusion of Group-O blood from plasma production, the chances of a Group-A patient receiving incompatible low-titred plasma is about 1 : 5 in respect of each unit administered. Group-B patients stand a very high chance of receiving incompatible plasma but, as has been demonstrated in the experiments referred to above,¹⁶ the possibility of ill effects in Group-B patients, even with massive transfusions, is extremely remote. In a case previously reported by the present author,¹⁷ a Group-B haemophiliac with uncontrolled bleeding received 83 pints of Group-O blood, 35 units of Group-A plasma and 25 pints of Group-B blood, all in a period of 35 days, without experiencing any untoward reaction.

SUMMARY

The methods adopted by the author in the preparation of 'unit-for-unit' dried plasma are outlined. This plasma has given extremely few febrile or other reactions.

The risk of transfusion of homologous serum jaundice is minimized by avoiding pooling and can probably be eliminated entirely by prolonged storage at room temperature before freeze-drying.

The risk of haemolytic transfusion reactions from iso-agglutinins in low-titred unpooled plasma is practically non-existent.

REFERENCES

1. Strumia, M. M. and McGraw, J. J. (1949): *Blood and Plasma Transfusions*, p. 95. Philadelphia: F. A. Davis Company.
2. White, C. S. and Wainstein, J. J. (1947): *Blood Derivatives and Substitutes*, pp. (a) 261, (b) 458. Baltimore: The Williams and Wilkins Company.
3. Greaves, R. T. N. (1949): *Blood Transfusion*, edited by Geoffrey Keynes, p. 509 *et seq.* Bristol: John Wright & Sons Ltd.
4. Macfarlane, R. G. *et al.* (1942): *Brit. Med. J.*, **1**, 377.
5. Reissmann, R. K. (1942): *Klin. Wschr.*, **21**, 127.
6. Maizels, M. (1944): *Lancet*, **2**, 205.
7. Editorial (1954): *J. Amer. Med. Assoc.*, **154**, 146.
8. Allen, J. G. *et al.* (1950): *J. Lab. Clin. Med.*, **36**, 796.
9. *Idem* (1954): *J. Amer. Med. Assoc.*, **154**, 105.
10. Murray, R. *et al.* (1954): *Ibid.*, **155**, 13.
11. Lozner, E. L. *et al.* (1946): *Blood*, **1**, 459.
12. Miller, E. B. and Tisdall, L. H. (1945): *J. Amer. Med. Assoc.*, **128**, 863.
13. Strumia, M. M., McGraw, J. J. and Blake, A. (1943): *Ann. Intern. Med.*, **19**, 48.
14. Levinson, S. O. and Cronheim, A. (1940): *J. Amer. Med. Assoc.*, **114**, 2097.
15. Thalheimer, W. (1942): *Ibid.*, **120**, 1263.
16. Crosby, W. H. and Akeroyd, J. H. (1954): *Blood*, **9**, 103.
17. Shapiro, M. (1952): *S. Afr. Med. J.*, **26**, 863.

ASSOCIATION NEWS : VERENIGINGSNUUS

JUNE MEETING OF THE GRIQUALAND WEST BRANCH

At the June meeting of the Griqualand West Branch of the Medical Association of South Africa held in the Board Room of the Kimberley Hospital on 17 June 1954, Dr. J. E. Vaughan Jones was in the Chair and 11 members attended.

After several items of business had been discussed the Chairman introduced Mrs. A. I. Salmon, Physiotherapist of the Diskobolos Schools, who had recently returned after a visit to various Institutions in Europe and England.

Mrs. Salmon read a paper on *Some Modern Aspects of Rehabilitation* illustrated by books, pamphlets and photographs of various institutions visited and different appliances and systems of therapy encountered. She described poliomyelitis treatment in fair detail and Guttman's treatment of paraplegics. She also discussed cerebral palsy. The problems of Rehabilitation in Industry and Geriatrics were also dealt with.

General discussion of the paper followed and the meeting was finally closed with a vote of thanks to the chair.

A VALUABLE PHYSIOLOGICAL STIMULANT

Research establishes the nutritive value of BOVRIL

In many illnesses, when gastric secretion is impaired and is deficient in hydrochloric acid, BOVRIL corrects this condition by restoring the normal volume and activity of the gastric juice, thus aiding the peptic digestion and absorption of protein foods.

BOVRIL is rich in protein, and is also specially valuable because of its high vitamin "B" content—two or three cups of BOVRIL supply the full adult daily requirement for nicotinic acid, and a not inconsiderable proportion of the riboflavin requirement, these being the principal substances comprised in the vitamin "B2" complex.

Intensive study of the nutritive value of meat extracts made during the recent war by both British and German chemists, shows that meat extracts have a much higher nutritive value

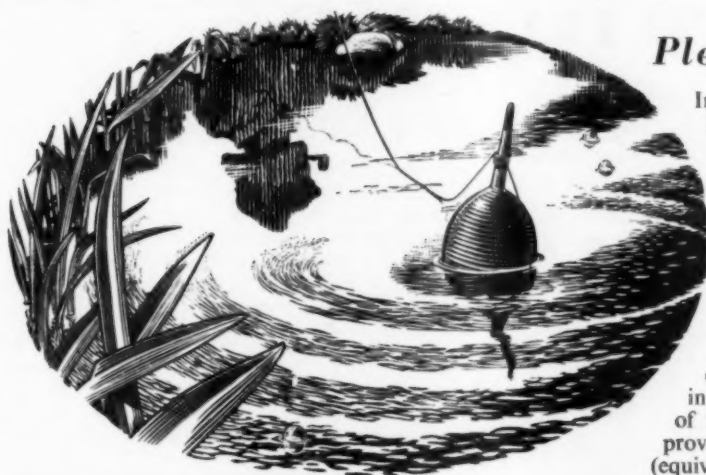
than was previously thought, while other independent tests have demonstrated that BOVRIL promotes a greater flow of gastric juices than any of the other gastric stimulants used in the tests.

BOVRIL is also rich in Sodium Glutamate, a protein component which has the unique property of enhancing the natural flavours of foods with which it is incorporated. Thus apart from its own most attractive and intense flavour, BOVRIL brings out the natural flavours of other foods, and it is to that extent a new-style condiment.

Everyone, therefore, who is run down through strain or illness, or who feels in need of extra strength to cope with the demands of modern life, should take a cup of hot BOVRIL daily. It is a delicious and stimulating way of keeping fit and strong.

BOVRIL *assists assimilation*

BE 42c



Pleasurable relaxation

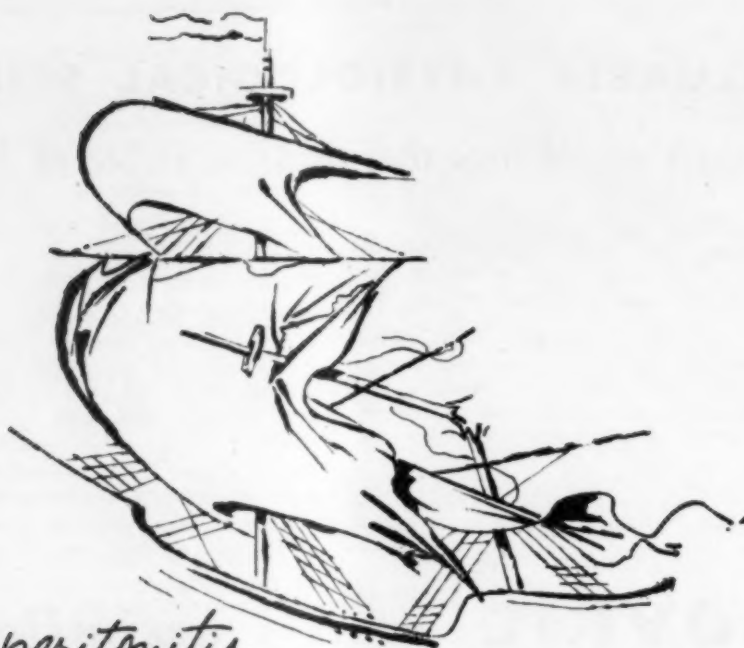
In addition to the established use of Myanesin Elixir in the treatment of neurological conditions associated with muscular rigidity and tremor it is successfully employed in the relief of psychological states characterised by anxiety and tension. Dixon *et al.* (Amer. J. Med. Sci., 1950, 220, 23) describe a group of patients in which anxiety states and obsessional conditions were present and which following the administration of mephenesin, the active constituent of Myanesin Elixir, obtained complete relaxation. Best results occurred in anxiety states, however chronic, and 47 out of 50 patients treated for this condition improved. Dosage of from $\frac{1}{2}$ to 1 tablespoonful (equivalent to 0.5 to 1 gramme), one to six times daily, is suggested.

'MYANESIN' ELIXIR

Contains 1 gramme mephenesin in each tablespoonful. Bottles of 8 fl. oz.
Also available in tablets containing 0.5 gramme.
Bottles of 25 and 100 tablets.

THE BRITISH DRUG HOUSES (SOUTH AFRICA PTY.) LTD. 123 JEPPE STREET JOHANNESBURG
LONDON • TORONTO • SYDNEY • BOMBAY • AUCKLAND

Myn/SAF/11a



in peritonitis

Terramycin*

BRAND OF OXYTETRACYCLINE

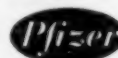
"Terramycin is established as a most useful and potent antibacterial agent," these authors conclude, after using Terramycin in the treatment of 68 patients with peritonitis. This drug was found to be particularly effective because of its "wide antimicrobial spectrum and good penetrability into peritoneal exudate . . ."

REGISTERED TRADE
MARK OF
CHAS. PFIZER & CO., INC.

Reiss, E.; Fainst, E. J.; Aron, C. F., and Shaffer, J. R.:
ARCH. SURG. 64:5-9 (JAN.) 1952

Distributor:

PETERSEN LTD.
P.O. Box 38, Cape Town
P.O. Box 5785, Johannesburg
113, Umbilo, Road, Durban,
South Africa.



EST. 1849

World's Largest Producers of Antibiotics

"GRAM FOR GRAM TERRAMYCIN IS UNEXCELLED AMONG BROAD-SPECTRUM ANTIBIOTICS"
PFIZER LABORATORIES SOUTH AFRICA (PTY.) LTD., P.O. BOX 7324, JOHANNESBURG.

DISTINCTIVE HYPOTENSIVE PREPARATIONS

PRODUCTS OF ORIGINAL RIKER RESEARCH

VERILOID (Plain)

This unique alkaloidal extract of *Veratrum viride* is one of the big items in the hypertension field. Veriloid, generically designated alkavervir, is used in all types of hypertension of all grades and severity. In 2 scored tablets; bottles of 100 and 500.

VERILOID-VP

Veriloid with Phenobarbital

Each scored tablet contains 2 mg. of Veriloid and 15 mg. of phenobarbital. Valuable when sedation is desired and to increase tolerance to Veriloid (plain) when side actions are an obstacle to arriving at a proper dosage. In bottles of 100 and 500.

THE PARENTERAL SOLUTIONS OF VERILOID

Solution Intramuscular Veriloid and Solution Intravenous Veriloid, containing respectively 0.4 mg. and 1.0 mg. of alkavervir per cc., are invaluable emergency drugs for the treatment of hypertensive crises. The former is supplied in 2 cc. ampuls in boxes of 6, the latter in 5 cc. ampuls in boxes of 6, and in a combination pack of one 5 cc. ampul and a 20 cc. vial of diluent.

RAUWILOID

Provides a purified uniform extract of selected alkaloids (alseroxylon fraction) from *Rauwolfia serpentina*. Produces mild sedation, bradycardia and lowering of blood pressure with virtual freedom from side actions. Particularly valuable in treatment of mild and moderate hypertension. Supplied in 2 mg. tablets; bottles of 50 and 250.

RAUWILOID + VERILOID

The apparent synergism between Rauwiloid and Veriloid is useful in treating severe and resistant hypertension, and in patients who cannot well tolerate Veriloid (plain). Each tablet contains 1 mg. of Rauwiloid, 3 mg. Veriloid. In bottles of 50 and 250.

RAUWILOID + HEXAMETHONIUM

Synergism between the Rauwiloid central vasodepressor action and the peripheral ganglionic blocking effect of the hexamethonium certainly exists. Up to 50 per cent reduction in normal Hexamethonium requirements can often be made. Together, these drugs produce better haemodynamic stability with marked decrease in the side effects usually experienced with hexamethonium alone. Each tablet contains 1 mg. Rauwiloid and 250 mg. Hexamethonium Chloride Dihydrate. In bottles of 50 and 250.

Literature available on request from:

**RIKER
LABORATORIES**

AFRICA (PTY.) LTD.

P.O. Box 1355, Port Elizabeth

and Los Angeles, Toronto, Loughborough



PRODUCES sustained bronchial and coronary dilatation.

REDUCES frequency and severity of attacks.

INDUCES subjective and objective improvement.

★ Benecardin is available for oral or intramuscular administration. Literature on request.

Further information is obtainable from —

BRITISH CHEMICALS & BIOLOGICALS (S.A.) (PTY.) LTD.

259 Commissioner Street, Johannesburg. P.O. Box 5788. Telephone 23-1915.

South African Medical Journal

Suid-Afrikaanse Tydskrif vir Geneeskunde

EDITORIAL

THE COMING 'REFERENDUM'

A Committee was appointed by the Federal Council of the Association to investigate the question of specialist registration and prepare the way for the postal vote on the subject which the Association is to organize in the near future amongst the whole medical profession of South Africa. Memoranda by this Committee were published in the *Journal* of 13 March 1954, and all Branches of the Association were asked to hold meetings, consider the memoranda, and submit to the Committee their recommendations as to how the memoranda—more especially the 'points for' and the 'points against'—should be altered or amplified.

The Committee considered the submissions and have now brought their labours to an end by issuing a final memorandum, the 'points for' and the 'points against' as finally amended, and the form of voting paper which they have devised. These documents are published in the present issue of the *Journal*. In 4 weeks' time they will be circulated to all members of the profession (those for residents overseas will be posted earlier) and the voting paper is to be detached and used for the purpose of the postal vote.* The voting papers when completed are to be returned to the Secretary of the Association, Cape Town, not later than Saturday, 4 September, and every member of the profession will do wisely to complete and return the voting paper immediately on receipt and not to put it aside for 'another day'.* It will be noted that the postal vote is not confined to members of the Association, but is extended to the whole profession.

Members are strongly urged at once to study carefully the documents which are now published and will later be circulated, and to include in their study the 'History of the Subject in South Africa', which was published in the *Journal* of 13 March 1954 on pages 216-223 and will, on account of its length, not be circulated with the other papers.

Broadly speaking, the Medical, Dental and Pharmacy Act of 1954 restores the legal position as it was supposed to be before June 1953, when the actions in this matter of the Minister of Health and the Medical and Dental

* It is not the specimen voting paper in the *Journal* that is to be detached and used, but the voting paper which will accompany the papers to be circulated in 4 weeks' time.

VAN DIE REDAKSIE

DIE AANSTAANDE REFERENDUM

Die Federale Raad van die Vereniging het 'n Komitee aangestel om ondersoek in te stel na die vraagstuk i.v.m. die registrasie van spesialiste en om die weg te baan vir reëlins wat die Vereniging sal tref vir die hele mediese professie van Suid-Afrika om binnekort oor hierdie onderwerp per pos te stem. Memoranda van hierdie Komitee het in die Tydskrif van 13 Maart 1954 verskyn en alle Takke van die Vereniging is gevra om vergaderings te hou, die memoranda te oorweeg en aanbevelings aan die Komitee te maak oor enige wysiging van of byvoeging tot die Memoranda—in besonder met betrekking tot die 'argumente ten gunste van' en 'argumente teen'.

Die Komitee het die aanbevelings oorweeg en het hul taak voltooi deur die uitreiking van 'n finale Memorandum, die 'argumente ten gunste van' en die 'argumente teen' soos finaal gewysig, en die stembriefvorm wat hul opgestel het. Hierdie stukke verskyn in die huidige uitgawe van die Tydskrif. Binne die loop van vier weke sal hul aan alle lede van die professie gestuur word (dié vir geneeshere oorsee sal vroeër geos word) en die stembrief moet deur die lede gebruik word om hul posstem uit te bring.* Die stembrief moet voltooi en, nie later as Saterdag 4 September 1954 nie, aan die Sekretaris van die Vereniging, Kaapstad, teruggestuur word. Elke lid van die professie sal verstandig optree deur dadelik op ontvangs die stembrief te voltooi en terug te stuur en dit nie op sy te skuif nie met die gedagte 'môre is nog 'n dag'.* Die posstemming is nie tot lede van die Vereniging beperk nie maar behels die hele professie.

Lede word dringend versoek om 'n sorgvuldige studie te maak van die stukke wat nou verskyn (en later gesirkuleer sal word) asook van die 'History of the Subject in South Africa', wat in die Tydskrif van 13 Maart 1954 op bladsye 216-223 gepubliseer is en wat te breedvoerig is om weer saam met die ander stukke gesirkuleer te word.

Die Wet op Geneeshere, Tandartse en Aptekers van 1954, herstel in die algemeen die regsposisie soos dit veronderstel was om te wees voor Junie 1953 toe die

* Dit is nie die eksemplairstembrief in die Tydskrif wat gebruik moet word nie maar die stembrief wat saam met die ander stukke binne 4 weke gesirkuleer word.

Council were declared *ultra vires* by the judgment in the Shapiro case. The structure that has been built up in the last 15 years has not collapsed, and the Council will continue to act as it has hitherto done. But assurances have been given by the Minister that the position is not to be regarded as final—that the door is not shut. He welcomes the projected 'referendum' to the profession and has, indeed, urged that all doctors should take part in the vote and that none should let it go by default. He has several times said that the profession must make up its mind what it wants, and that he will listen to what they say. The Medical Council is also awaiting the result of the 'referendum' and will consider it at the earliest opportunity.

The occasion is truly momentous. It may fairly be said that the country is waiting on the decision of the profession. The future of the practice of medicine may largely be determined by the result of this poll. Let us all vote, and let us anxiously strive to vote wisely.

optrede van die Minister van Gesondheid en die Mediese en Tandheelkundige Raad in die Shapiro-saak *ultra vires* verklaar is. Die stelsel wat gedurende die afgelope 15 jaar opgebou is het nie in duie gestort nie en die Raad sal voortgaan om soos in die verlede op te tree. Die Minister het egter duidelik te kenne gegee dat die posisie nie as finaal afgehandel beskou moet word nie. Hy verwelkom die referendum aan die professie en het inderdaad dit benadruk dat elke geneesheer sy stem behoort uit te bring. Op verskeie geleenthede het hy dit duidelik gestel dat die professie self moet besluit wat dit wil hê en dat dié besluit sy aandag sal geniet. Die Mediese Raad wag ook op die uitslag van die referendum en sal dit so gou moontlik oorweeg.

Dit is inderdaad 'n betekenisvolle gebeurtenis. Dit kan tereg gesê word dat die land op die professie se besluit wag. Die toekoms van geneeskundige praktyk in ons land kan tot 'n groot mate deur die uitslag van die stemming bepaal word. Laat ons almal stem en ons uiterste bes doen om verstandig te stem.

THE LABORATORY CONTROL OF TUBERCULOUS MENINGITIS

With the advent of more successful chemotherapeutic measures against tuberculous meningitis, the laboratory control of this disease has assumed a more practical significance.

It is, therefore, profitable to reconsider the newer disciplines of this laboratory control. The following programme is thus suggested as a guide so that the laboratory is used neither too frequently nor too sparingly.

It is a *sine qua non* that comprehensive clinical data are essential. For instance, it is often not realized that residual streptomycin or P.A.S. in the cerebrospinal fluid tends to give higher 'glucose' levels than do in fact exist; or that co-existent raised intracranial pressure, uraemia, and of course diabetes mellitus, would also tend to elevate the true glucose levels. Information bearing on these matters would influence the interpretation of these values. And, again, if the clinical data, chemistry and cytology suggest an alternative diagnosis to tuberculous meningitis, then the laboratory would, of its own accord, pursue such a prospect—frequently with rewarding results.

For the diagnosis of tuberculous meningitis 5 cubic centimetres, or more, of cerebrospinal fluid is sent in sterile tubes to reach the laboratories within 2-3 hours. If additional delay is anticipated then the fluid should be refrigerated whilst awaiting dispatch, and should be sent in 'fluoride tubes'. Whilst a diagnosis is not possible on the chemistry values only, yet a low glucose level in a fresh non-turbid cerebrospinal fluid, is very suggestive evidence of tuberculous meningitis.

Three consecutive daily specimens should be sent, labelled '1', '2' or '3'. As intrathecal streptomycin will alter the cerebrospinal fluid (raising the cell count, for instance) the biochemistry and cytology is only of value on the first specimen. On each of the 3 specimens a direct microscopic examination for tubercle bacilli is

done in the first instance—this examination may have a success rate of over 80% in some laboratories. If preliminary direct examination fails to reveal tubercle bacilli then a culture or guinea-pig inoculation is done; the results of these may not be available for one month.

To follow the course of the disease during intrathecal treatment, specimens of cerebrospinal fluid should be investigated every week for its chemistry and cytology. This schedule commences one month after the initial diagnosis.

If the response to treatment is variable, then cerebrospinal fluid should be sent for culture and for sensitivity tests against streptomycin and I.N.H. This result may not be available for 6 weeks.

Absence of polymorphonuclear leucocytes and a return to normal of the chloride level, are early indications of a successful trend, but intrathecal treatment should not be stopped until the chemistry, the cytology and the patient's weight are progressively approaching normal or have become normal and the patient is afebrile. If this progressive approach to normal values of the cerebrospinal fluid is not maintained, then the intrathecal therapy should be resumed. Systemic treatment then continues for a further 6 months, during which time the cerebrospinal fluid is examined at fortnightly intervals.

During subsequent convalescence the cerebrospinal fluid should be examined every month for 6 months and then every 3 months for a further 2-3 years. Where residual meningeal adhesions have caused a spinal block, the laboratory values may not return to normal after many months of persistent treatment and apparently complete clinical recovery.

REFERENCE

- Barnard, C. N. (1954): Personal communication based on experience from the City Hospital for Infectious Diseases, Cape Town, and a thesis on Tuberculous Meningitis.

SPECIAL SUB-COMMITTEE TO ENQUIRE INTO THE REGISTRATION OF SPECIALISTS — SPESIALE SUBKOMITEE OM ONDERSOEK IN TE STEL NA DIE REGISTRASIE VAN SPESIALISTE

MEMORANDUM

In an attempt to determine the views of the medical profession with regard to the retention, modification or alteration of the Specialist Register, the Federal Council of The Medical Association of South Africa is enclosing a Questionnaire.

It is hoped that before attempting to answer the questionnaire, every medical practitioner will first have made a conscientious study of the memoranda of the Sub-Committee of Federal Council, as published in the *South African Medical Journal* of 13 March 1954, pages 216-226. In addition, lists of points for and against the possible forms of Registration as enclosed with this questionnaire *must be carefully studied*.

To enable the profession to answer Question A of the questionnaire, the conditions which existed before any Specialist Register was instituted in 1938 are again outlined, viz:

POSITION PRIOR TO 1938

Any medical practitioner could announce (by putting up a plate) that he intended restricting himself to a speciality or acting as a Consultant, and was entitled to do so. He was required to conform to certain ethical rules of conduct. The rules read as follows:

'(1) Holding himself out as a specialist unless he confines his professional work entirely to such speciality or associated specialities as bracketed together in the Schedule appearing below.'

[Then followed the Schedule; certain specialities appeared as 'Bracketed', which meant that persons could practise more than one speciality provided they were associated specialities.]

'(2) Holding himself out as a Consultant when attending and treating patients except in consultation with or at the request of other practitioners.'

Thus, a Specialist was a person who restricted himself entirely to his speciality, and a Consultant was one who only saw and attended cases with, or at the request of, other practitioners. Anybody could set himself up as a Specialist or as a Consultant without having to conform with any specified requirements.

PRESENT POSITION

The rules relating to the position of Specialists and Consultants at present are as follows:

Rules regarding Conduct of which the Medical Council may take Cognisance:

'Rule 1. Holding himself out as a Specialist, unless he has been recognised as such by the Council and his speciality has been registered, and he con-

MEMORANDUM

In 'n poging om die mening van die mediese professie te bepaal i.v.m. die instandhouding of die wysiging van die Spesialisregister, sluit die Federale Raad van Die Mediese Vereniging van Suid-Afrika hiermee 'n Vraelys in.

Dit word verwag dat, alvorens die vrae beantwoord word, elke geneesheer eers 'n pligsgetroue studie van die memoranda van die Federale Raad se Subkomitee moet maak. Hierdie memoranda het in die *Suid-Afrikaanse Tykskrif vir Geneeskunde* van 13 Maart 1954 op bladsye 216-226 verskyn. Boonop moet die meegaande lysie van bewerings vir en teen moontlike vorms van Registrasie deeglik bestudeer word.

Ten einde die professie in staat te stel om Vraag A van die vraelys te beantwoord, word die toestand van geheers het voor die instelling van die Spesialisregister in 1938 weer in breë trekke hieronder uiteengesit:

TOESTAND VOOR 1938

Enige geneesheer kon (deur sy plaat op te sit) aankondig dat hy homself beperk tot 'n spesialiteit of as konsulerende geneesheer, en was geregtig om dit te doen. Dit was van hom vereis om sekere etiese gedragsreëls na te kom. Hierdie reëls lui as volg:

„(1) Homself as 'n spesialis voordoen tensy hy sy professionele werk geheel en al beperk tot sodanige spesialiteit of verwante spesialiteite soos saamgekoppel in die Bylae hieronder:'

[Die Bylae het gevolg; sekere spesialiteite is saamgekoppel. Dit het beteken dat persone as spesialiste in meer as een spesialiteit kon praktiseer mits sodanige spesialiteite saamgekoppel was.]

„(2) Homself as konsulerende geneesheer voordoen wanneer hy oor 'n pasiënt gaan behalwe in konsultasie met, of op versoek van, ander geneesheer.'

'n Spesialis was dus 'n persoon wat homself geheel en al tot sy spesialiteit beperk het, en 'n konsulerende geneesheer 'n persoon wat alleen gevalle geneem en behandel het saam met, of op versoek van, ander geneesheer. Enigeen kon as spesialis of konsulerende geneesheer praktiseer sonder om aan enige spesifieke vereistes te voldoen.

HUIDIGE TOESTAND

Op die oomblik is die volgende reëls op Spesialiste en Konsulerende Geneesheer van toepassing:

Reëls betreffende Gedrag waarvan die Mediese Raad kennis kan neem:

„Reël 1. Hom as 'n spesialis voordoen, tensy hy as sodanig deur die Raad erken, en sy spesialiteit geregistreer is, en hy sy praktyk uitsluitlik beperk

finishes his practice entirely to such speciality or associated specialities, bracketed together as under, as are included in the Schedule appearing below, or to such other speciality or associated specialities as may from time to time be added by resolution of the Council:--' (Schedule follows.)

'Notes. (i) the retention of the name of a practitioner's speciality in the Register shall be contingent on the practitioner confining his practice to his speciality. It is, however, understood that it is incumbent on a specialist to include in his consultation fee such other examinations as are usually performed by general practitioners, and that a specialist shall not charge extra fees for examinations or procedures which properly fall under other specialities.

(ii) A specialist receiving a patient sent to him by another practitioner must behave as a consultant and send the patient back to such practitioner unless specially asked by such practitioner to continue to treat the case.

(iii) A specialist may treat any person who may come to him direct for consultation.'

'Rule 2. Holding himself out as a consultant when attending and treating patients except in consultation with and at the request of other practitioners.'

DEFINITIONS

Specialist

A Specialist is a medical practitioner who:

1. restricts himself entirely to a speciality or associated specialities;
2. on receiving a patient sent to him by another practitioner, must behave as a Consultant and send the patient back to such practitioner unless specially asked by such practitioner to continue to treat the case;
3. may treat any patient who may come to him direct for consultation;
4. according to Medical Council rules, is not precluded from doing domiciliary visiting, but who does not customarily do such visiting except in cases of emergency or when called upon to do so in a Consultant capacity by another medical practitioner.

Consultant

A Consultant is a medical practitioner who only attends and treats patients in consultation with, or at the request of, other practitioners.

8 June 1954

POINTS WHICH HAVE BEEN ADVANCED IN FAVOUR OF A SPECIALIST REGISTER

1. With the great advancement in medical science during the last 30-40 years, specialism has become essential and inevitable.

It is necessary that the public and the members of the profession should know that any member of the profession who holds himself out as a specialist or consultant has had a definite minimum training to justify such a claim. For such a purpose, some form of registration is of assistance.

tot een van die spesialiteite of verwante spesialiteite, soos gegroepeer en vervat in die Bylae hieronder, of tot sodanige ander spesialiteit of verwante spesialiteite wat van tyd tot tyd deur besluit van die Raad bygevoeg mag word.'

'Opmerking (i) Die naam van 'n praktisyn se spesialiteit word in die register behou mits die praktisyn sy praktyk tot sy spesialiteit beperk. Dit is egter die plig van 'n spesialis om by sy konsultasiegelde sodanige ander ondersoek wat in die reël deur algemene praktisyns uitgevoer word, in te sluit en 'n spesialis moet nie addisionele gelde vir ondersoek of prosedures wat eintlik onder ander spesialiteite val, vra nie.

(ii) Wanneer 'n spesialis 'n pasiënt wat deur 'n ander praktisyn na hom gestuur is, ontvang, moet hy as konsulerende geneesheer optree en die pasiënt na die praktisyn terugstuur, tensy hy spesiaal deur die praktisyn versoek is om die behandeling van die geval voort te sit.

(iii) 'n Spesialis kan enigeen behandel wat direk na hom kom om hom te raadpleeg.'

'Reël 2. Hom uitgee vir 'n konsultant by die behandeling van pasiënte, uitgesonderd in konsultasie met en op versoek van ander praktisyns.'

WOORDOMSKRYWING

Spesialis

'n Spesialis is 'n mediese praktisyn wat:

1. homself geheel en al tot 'n spesialiteit of verwante spesialiteite beperk;
2. wanneer 'n pasiënt deur 'n ander praktisyn na hom verwys is as konsulerende geneesheer optree en die pasiënt na sodanige praktisyn terugstuur tensy hy spesiaal deur sodanige praktisyn versoek is om met die behandeling van die geval voort te gaan;
3. enige pasiënt mag behandel wat hom regstreeks vir konsultasie nader;
4. ingevolge die reëls van die Mediese Raad nie verhoed is om huisbesoek af te lê nie, maar wat nie sulke besoeke as 'n reël aflê nie behalwe in noodgevalle of wanneer daartoe in 'n konsulerende hoedanigheid deur 'n ander mediese praktisyn versoek.

Konsulerende Geneesheer

'n Konsulerende geneesheer is 'n mediese praktisyn wat alleenlik oor pasiënte gaan saam met, of op versoek van, ander geneeshere.

8 Junie 1954

ARGUMENTE WAT TEN GUNSTE VAN 'N SPESIALISREGISTER GEOPPER IS

1. As gevolg van die groot vooruitgang op die gebied van geneeskunde gedurende die afgelope 30-40 jaar is spesialisasie noodsaaklik en onvermydelik.

Dit is vir die publiek en lede van die professie noodsaaklik om verseker te wees dat enige lid van die professie wat homself as 'n spesialis of konsulerende geneesheer voordoen 'n definitiewe minimum opleiding geniet het wat sodanige aanspraak regverdig.

2. A register of specialists has been kept in some countries for years, and in South Africa for 15 years; it is felt by many that its abolition now would lead to chaos, as so many agreements involving Governmental, Provincial and Municipal Departments, Medical Aid and Benefit Societies, etc., have been entered into on the basis of a specialist register. Also, there could be exploitation of patients by medical men not properly trained as specialists if the control of the specialist register and the rules governing it were removed.

3. The public is jealous of its rights and would not wish to be restricted in the direct access of patient to the specialist.

The profession has always insisted on free choice of doctor by the patient, and it is difficult to see how the profession can now insist that such a rule must not apply as far as specialists are concerned.

POINTS WHICH HAVE BEEN ADVANCED IN FAVOUR OF STATUTORY REGISTRATION

1. Through the Medical, Dental and Pharmacy Act, one of the duties of the South African Medical and Dental Council is to see that undergraduate medical education is kept up to a proper standard. This is for the benefit of the public.

The public is as interested in upholding a high standard of postgraduate education and specialization as is the profession, and it is argued, therefore, that there is, at any rate at present, no better body than the South African Medical and Dental Council to lay down standards for specialization.

2. The fact that this body is also entrusted with upholding the ethical standards of the profession is an additional point in favour of the registration of specialists being in its hands. A non-statutory body would not have the power to impose penalties for infringements of the rules relating to specialist registration and practice.

3. The fact that only a few countries have a statutory register does not mean that this is not the best course to follow in South Africa.

4. Many in favour of the South African Medical and Dental Council carrying on with the specialist register—i.e., upholding the *status quo*—are of the opinion that it is better to carry on as at present unless, or until, some other method which would appear to be more satisfactory is brought forward.

5. It is doubtful whether any non-statutory body would undertake the arduous duties of keeping a register of any kind.

POINTS WHICH HAVE BEEN ADVANCED IN FAVOUR OF A CONSULTANT REGISTER WITHOUT A REGISTER OF SPECIALISTS

1. The fee structure for specialists can be justified on the basis of their practising as consultants. There is a very large differentiation between the consultation fee for a general practitioner and a consultant, because:

- (a) The consultant's cases must be limited in number.
- (b) They are selected, difficult cases.
- (c) There must be a consultation with or a report to the practitioner referring the case, in addition to the services to the patient.

2. The interests of the consultant and the general practitioner do not conflict; they are complementary.

3. Medical Benefit Societies employ specialists as consultants.

4. In Medical Aid Societies, specialists may be consulted only as consultants at the request of the general practitioner. The profession approves of this arrangement, and the Societies agree because it provides an adequate service more cheaply.

5. By tradition, domiciliary visiting by specialists has been overwhelmingly in a consultant capacity. It is, therefore, paradoxical that the specialist should insist on the right to see patients at his rooms who have not been referred to him by his colleagues.

6. The creation of a register of specialists who are not consultants must result, in some cases, in a conflict of interest between the specialist and the general practitioner. Fear of, or suspicion of, unfair competition must arise. Within the range of his speciality, the specialist who does not act as a consultant may be in direct competition with the general practitioner, with the added ad-

Een of ander vorm van registrasie sal vir hierdie doel van hulp wees.

2. Sommige lande het al vir jare so 'n spesialisregister gehad, Suid-Afrika vir 15 jaar; baie is die mening toegedaan dat die afskaffing daarvan tot chaos sal lei daar so baie ooreenkomste waarin Staats-, Provinsiale, en Munisipale Departemente, Hulpverenigings, ens. betrokke is, op grondslag van 'n spesialisregister aangegaan is. Verder is dit moontlik dat as die spesialisregister en die reëls wat dit beheer afgeskaf word, pasiënte uitgebuit kan word deur medici wat nie behoorlike spesialisopleiding ontvang het nie.

3. Die publiek is op sy regte gesteld en sal nie ten gunste daarvan wees om regstreekse toegang van pasiënt tot spesialis te beperk nie.

Die beroep het nog altyd op die pasiënt se vrye keuse van geneesheer aangedring en dit is moeilik om te begryp hoe die beroep nou kan aandrang dat dié vrye keuse nie op spesialiste van toepassing moet wees nie.

ARGUMENTE WAT TEN GUNSTE VAN STATUTÊRE REGISTRASIE GEOPPER IS

1. Ingevolge die Wet op Geneeshere, Tandartse en Aptekers is een van die pligte van die Suid-Afrikaanse Geneeskundige en Tandheelkundige Raad om toe te sien dat 'n behoorlike standaard van voorgaande mediese opleiding gehandhaaf word. Dit is tot voordeel van die publiek.

Dit is van ewe groot belang vir die publiek en die professie om 'n hoë standaard van nagraadse opleiding en spesialisasie te handhaaf en die redenering is derhalwe dat daar, op die oomblik althans, geen ander liggaam bestaan nie wat beter daartoe in staat is om die standaard van spesialisasie vas te lê as die Suid-Afrikaanse Geneeskundige en Tandheelkundige Raad.

2. Die feit dat die handhawing van die etiese standaard van die professie aan hierdie liggaam toevertrou is, is 'n addisionele rede waarom die registrasie van spesialiste aan dié liggaam oorgelaat word. 'n Nie-statutêre liggaam sal nie by magte wees om oortredings van die reëls i.v.m. spesialisregistrasie en praktyk te straf nie.

3. Die feit dat net 'n paar lande 'n statutêre register het beteken nie dat dit nie vir Suid-Afrika die beste pad is om te volg nie.

4. Baie wat ten gunste daarvan is dat die Suid-Afrikaanse Mediese en Tandheelkundige Raad met die spesialisregister moet voortgaan—d.w.s. die status quo moet handhaaf—is van mening dat dit beter is om die huidige stelsel te handhaaf tensy, of totdat, 'n ander metode voorgestel word wat meer bevredigend voorkom.

5. Dit is twyfelagtig of enige nie-statutêre liggaam die moeilike taak, om 'n register van enige soort te hou, sal aanpak.

ARGUMENTE WAT GEOPPER IS TEN GUNSTE VAN 'N REGISTER VIR KONSULTERENDE GENEESHERE SONDER 'N REGISTER VAN SPESIALISTE

1. Die stelsel van gelde vir spesialiste kan op grondslag dat hul as konsulerende geneeshere praktiseer verdedig word. Daar is 'n baie groot verskil in die konsultasiegeld vir 'n algemene geneesheer en 'n konsulerende geneesheer omrede dat:

- (a) Die konsulerende geneesheer se pasiënte moet noodwendig beperk wees in getal.
- (b) Hulle is uitgesoekte, moeilike gevalle.
- (c) Behalwe die dienste aan die pasiënt gelewer moet daar samespreking wees met of 'n verslag aan die geneesheer wie se pasiënt dit is.

2. Die belange van die konsulerende geneesheer en die algemene geneesheer bots nie; hulle is aanvullend.

3. Mediese Bystandverenigings maak gebruik van spesialiste as konsulerende geneeshere.

4. In Mediese Hulpverenigings mag spesialiste net as konsulerende geneeshere geraadpleeg word op versoek van die algemene geneesheer. Die professie keur hierdie reëling goed en die verenigings is daarmee eens want dit voorsien 'n doeltreffende diens goedkoper.

5. Tradisioneel word huisbesoeke deur spesialiste in verreweg die meeste gevalle in 'n konsulerende hoedanigheid afgelê. Dit is derhalwe 'n paradoks dat die spesialis op die reg aandrang om pasiënte in sy kamers te sien wat nie na hom deur sy kollegas gestuur is nie.

6. Die instelling van 'n register van spesialiste wat nie konsulerende geneeshere is nie moet in sommige gevalle die uitwerking hê dat die belange van die spesialis en die algemene geneesheer

vantage of a title of 'Specialist' conferred upon him by the Medical Council. Some specialists, like that of specialist physician, cover the major portion of the general practitioner's work.

In obstetrics, in the cities, the competition between the general practitioner and the specialist is causing a revolution in practice. The general practitioner who calls in a specialist as a consultant is likely to feel that he is simply advertising his competitor.

7. A register of consultants raises no problem for the general practitioner. It raises no real problem for the public, for in contract practice specialist services are available in consultant form, and this is not inferior practice.

8. Under the system of consultants, the ratio of specialists to general practitioners will be automatically regulated by the real need for consultant advice and treatment, and the public will not be deprived of those specialized services which modern medical practice demands.

9. If there was a consultant register only, the general practitioner would not be tempted to undertake work which was beyond his competence in order to maintain his status in the eyes of his patient *vis a vis* the specialist. This would result in more harmonious relations between the general practitioner and the specialist, and more work would probably be referred to consultants than at present.

10. (a) With a consultant register, it is felt that there would be a re-awakening to the advantages of general practice by many practitioners with additional qualifications and/or specialist training. It would stimulate the formation of 'Group Practice', where a team of practitioners would be in a position to give first-class service to their patients, and raise the status (much belittled) of the general practitioner of the future, by permitting each member of the group to concentrate on some facet of the rapidly accumulating volume of scientific knowledge as applied to medicine to-day.

(b) Furthermore, in reference to item (a) above, a general practitioner with specialist training, and/or a higher qualification, would once again be able to hold appointments at hospitals in a 'specialist capacity', which would be advantageous to him in maintaining his connection with his specialty, and once again raise the standard of his service as a general practitioner.

POINTS WHICH HAVE BEEN ADVANCED AGAINST STATUTORY REGISTRATION OF SPECIALISTS

1. Statutory registration of specialists results in the laying down of rules and regulations governing the qualifications required. The conditions under which these can be fulfilled are outside the control of the registering body. This results in the control of opportunity for education towards specialism being in the hands of outside bodies, such as the Provincial Administration and the Universities.

2. Conformity with the rules does not enable the registering body to give a guarantee of competence. Great competence in any field of medicine may be acquired by methods other than these laid down in the rules. Competence so acquired may not receive recognition.

3. Although a practitioner might have many years' experience in general practice and have done a good deal of postgraduate work, the present rules make it difficult for him to get onto the specialist register, because he has to do a certain amount of full-time hospital work.

Facilities for doing specialized work are limited and thus those who remain in line of succession at the medical school are likely to get whatever posts for full-time work are available. Therefore, individuals in general practice who wish to specialize will have great difficulty in getting the full-time posts which are necessary to enable them to get onto the specialist register.

The general practitioner who wishes to specialize must obtain an appointment in a teaching hospital, whereas there are many other hospitals where he could obtain good training and experience.

For economic reasons the general practitioner frequently finds it impossible to accept a full-time appointment.

4. As a result of statutory registration of the specialist, ability and knowledge are attributed to him by the public allegedly far in excess of that of a general practitioner, and no cognizance is

bots. Vrees vir, of agterdog oor, onbillike wedywering ontstaan. Binne die bestek van sy eie gebied, kan die spesialis wat nie konsulerend optree nie direk met die algemene praktisyen meeding met die addisionele voorsprong van die titel spesialis wat aan hom deur die Mediese Raad verleen is. Sommige spesialiteite, soos byvoorbeeld Interne Geneeskunde, dek die grootste deel van die algemene praktisyen se werk. Die mededinging in die stede op die gebied van verloskunde is besig om 'n ommekeer in die praktyk te veroorsaak. Die algemene praktisyen wat 'n spesialis vir konsultasie ontbied sal waarskynlik voel dat hy eenvoudig reklame vir sy mededinger maak.

7. 'n Register van konsulerende geneesheer bied geen vraagstuk vir die algemene geneesheer nie. Dit bied ook geen werklike probleem vir die publiek nie, want in kontrakpraktyk is die dienste van spesialiste in konsultvorm beskikbaar en dit word nie as minderwaardige praktyk beskou nie.

8. Met 'n stelsel van konsulerende geneesheer sal die verhouding van spesialiste tot algemene geneesheer outomaties geregleer word deur die werklike behoefte aan konsulerende dienste en die publiek sal nie van dié gespesialiseerde dienste, wat hedendaagse mediese praktyk vereis, ontse word nie.

9. Indien daar net 'n register van konsulerende geneesheer bestaan, sal die algemene geneesheer nie in die versoeking val nie om werk te doen waarvoor hy nie bevoeg is nie om sodoende sy status in die oë van sy pasiënt *vis a vis* die spesialis te behou. Dit sal aanleiding gee tot 'n gesonder verstandhouding tussen die algemene praktisyen en die spesialis en daar sal 'n groter aanvraag vir die dienste van konsulerende geneesheer wees as wat op die oomblik die geval is.

10. (a) Die mening word gehuldig dat as 'n register van konsulerende geneesheer ingestel word geneesheer met addisionele kwalifikasies en/of spesialisopleiding weer in die voordele verbonde aan algemene praktyk sal belangstel.

Dit sal die instelling van groeppraktyk aanmoedig; sodoende kan 'n span geneesheer eerste klas dienste aan pasiënte lewer en die status (baie geringgeskat) van die toekomstige algemene geneesheer verhoog, deurdat elke lid van die groep op een of ander faset van die sneltoenemende wetenskaplike kennis op gebied van die hedendaagse geneeskunde kan konsentreer.

(b) Met verwysing tot item (a) hierbo, kan die algemene geneesheer met spesialisopleiding en/of hoër kwalifikasie weer eens in staat gestel wees om hospitaalbetrekkings in 'n spesialishoedanigheid te beklee. Dit sal hom tot voordeel strek want hy sal dan kan tred hou met sy spesialiteit en dit sal weer eens die standaard van sy dienste as algemene geneesheer verhoog.

ARGUMENTE WAT TEEN STATUTÊRE REGISTRASIE VAN SPESIALISTE GEOPPER IS

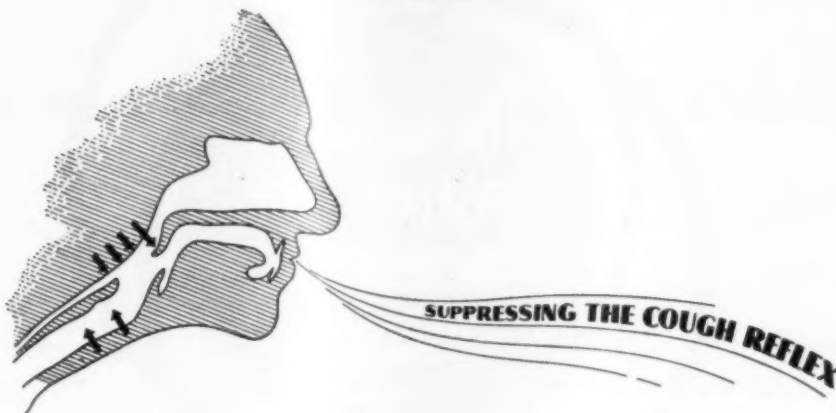
1. As gevolg van statutêre registrasie van spesialiste moet reëls en regulasies vir die vereiste kwalifikasies voorgeskryf word. Die omstandighede waaronder hul uitgevoer word val buite die beheer van die registrerende liggaam. Die resultaat is dat die beheer van die geleentheid tot spesialisopleiding onder buitestaande liggame, soos die Provinsiale Administrasie en die Universiteite, staan.

2. Onderwerping aan die reëls stel die registrerende liggaam nie in staat om bevoegdheid te waarborg nie. Buitengewone bevoegdheid kan op enige gebied van die geneeskunde deur ander metodes verwerf word as wat die reëls voorskryf. Bevoegdheid wat op dié manier verkry word mag moontlik nie erken word nie.

3. Alhoewel 'n geneesheer jarelange ondervinding van algemene praktyk besit en aansienlike nagraadse werk agter die rug het, is dit vir hom moeilik om onder die huidige reëls op die spesialisregister te kom, aangesien dit van hom vereis word om 'n bepaalde hoeveelheid voltydse hospitaalwerk te doen.

Die geleentheid om gespesialiseerde werk te doen is beperk en diegene wat by hul Mediese Skole aanbly staan dus 'n beter kans om beskikbare betrekkings vir voltydse werk te bekom. Geneesheer in die algemene praktyk wat wil spesialiseer sal derhalwe groot moeilikheid ondervind om dié voltydse betrekkings te bekom wat 'n vereiste vir opname op die spesialisregister is.

Die algemene geneesheer wat graag wil spesialiseer moet 'n aanstelling in 'n opleidingshospitaal bekom terwyl daar baie ander hospitale is waar hy ook goeie opleiding kan geniet en goeie ondervinding kan opdoen.



A new basic ether of morphine, Pholcodine (morpholinylethylmorphine), has been shown to have a powerful action in depressing the cough reflex.

Pholcodine, which has a sedative action superior to that of codeine while being decidedly less toxic, is employed as the active ingredient in a new cough linctus to which the name ETHNINE has been given.

The advantages of ETHNINE lie in its effectiveness with low toxicity, and its freedom from side-effects such as constipation or digestive upset.

ETHNINE is well tolerated by children and adults and is suitable for administration whenever a cough sedative is considered advisable.

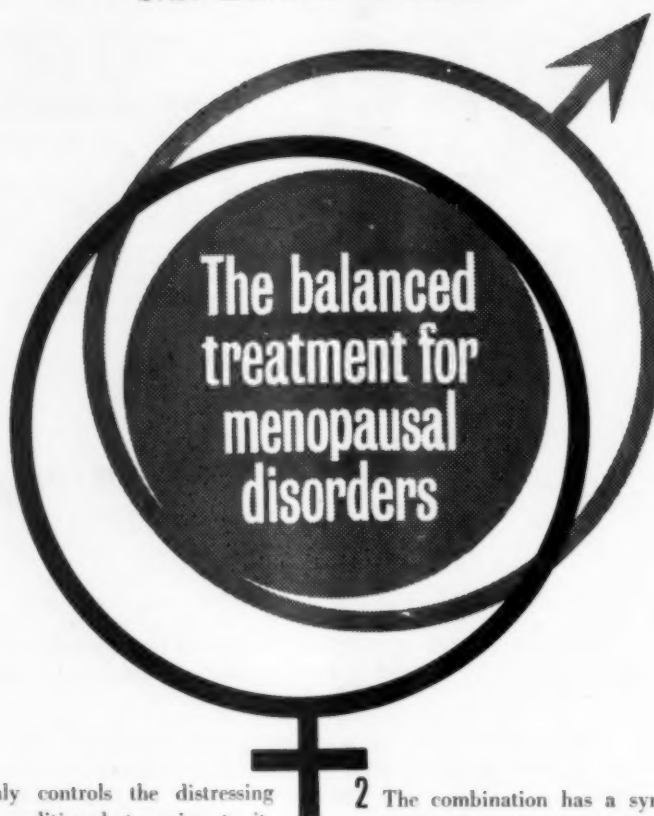
ETHNINE

CONTAINING PHOLCODINE

In bottles of 4 and 80 fluid ounces.

Literature and sample on application.

ALLEN & HANBURY'S (AFRICA) LTD
INCORPORATED IN ENGLAND
121 CONELLA ROAD • DURBAN



DUOSTAB not only controls the distressing symptoms of the condition but, owing to its anabolic effect, increases the sense of well-being.

DUOSTAB tablets contain ethinyloestradiol, 0.01 mg., and methyltestosterone, 3 mg. The concomitant use of oestrogen and androgen in this physiologically-balanced mixture has the following therapeutic advantages —

1 The blood concentrations of oestrogen and androgen produced approximate closely to the normal physiological levels of the two types of hormone.

2 The combination has a synergistic trophic effect on the vaginal epithelium.

3 The presence of the androgen permits an optimal effect to be produced with a diminished dose of oestrogen, thus reducing the risk of uterine haemorrhage.

4 There is a minimum of interference with the changes normal to the menopause, whilst the untoward symptoms are adequately controlled.

DUOSTAB

Tablets, each containing:

Ethinyloestradiol, 0.1 mg.

Methyltestosterone, 3 mg.

Available in bottles of 25 and 100

B.P.D. (S.A.) (Pty.) Ltd.
275 Commissioner St., Johannesburg
P.O. Box 45, Jeppestown, Transvaal.



TO SOUTH AFRICAN PHYSICIANS

An unusual offer

YOU ARE INVITED TO MAKE THE "BERMIDE TEST" FOR ARTHRITIC AND RHEUMATIC DISORDERS AT OUR EXPENSE

Nothing we could tell you about the efficacy of Succinate-Salicylate Oral Therapy (Bermide) for Arthritic and Rheumatic disorders could be half so convincing as observing results with your own patients. That's why we make this unusual offer:

We will supply GRATIS a quantity of BERMIDE sufficient for you to make your own "BERMIDE TEST" with two patients suffering from Arthritic or Rheumatic disorders.

In this way . . . without incurring any obligation whatever . . . you will have an opportunity to observe, at first hand, the dramatic response to BERMIDE Oral Therapy.

This South African "BERMIDE TEST" will parallel a similar test made by Canadian physicians last year by which much valuable clinical data concerning Succinate-Salicylate Therapy was amassed. Results there indicated that in a wide range of arthritic and rheumatic disorders, the BERMIDE formula therapy produced *marked improvement* in over 84% of cases.

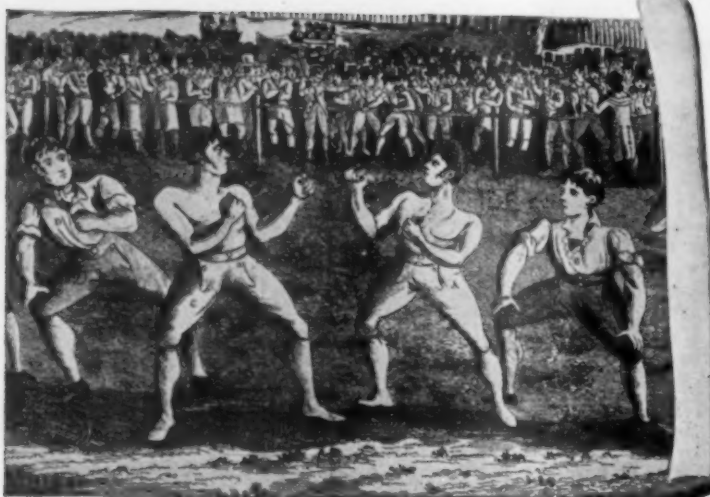
We urge you to make the "BERMIDE TEST" at our expense. Prove to yourself that in the treatment of osteoarthritis, rheumatoid arthritis, rheumatic fever, myositis, fibrositis, bursitis or sciatic neuritis, BERMIDE provides dramatic benefits.

IMMEDIATELY ON RECEIPT OF A REQUEST FROM YOU . . . we will send you the large-size dispensing bottle of 500 BERMIDE tablets, together with complete recommendation for dosage. Additional supplies will be furnished as required so that your personal test of Succinate-Salicylate (BERMIDE) Oral Therapy may be conclusive.

BERMIDE is available in bottles of 100, and in the 500-tablet dispensing size at your prescription pharmacy. Manufactured under licence. BERMIDE is the trademark of this product.

**Bermide**

THE PAN PHARMACALS COMPANY,
P.O. BOX 4247, JOHANNESBURG, S.A.



Two-fisted attack on **MIXED** infections...

If you seek a simple, effective answer to mixed infections, look to SECLOMYCIN. One injection provides the combined antibacterial activity of penicillin and streptomycin, so bringing an intensive attack to bear on both gram-positive and gram-negative organisms. This is precisely the attack called for to combat mixed or resistant infections that fail to respond to either penicillin or streptomycin alone.



Dry powder for aqueous suspension
"Single-dose" vials in boxes of 10

SECLOMYCIN

Trade mark

GLAXO LABORATORIES (S.A.) (PTY.) LTD., P.O. BOX 9875, JOHANNESBURG

Agents: M. & J. Pharmaceuticals (Pty.) Ltd., P.O. Box 784, Port Elizabeth

That little extra...

In nutrition, as well as in the sporting world, that *little extra* can prove a vital factor. A daily ration of vitamins A and D, for instance, can make all the difference between a succession of colds and chills and robust health. During infancy, adolescence and pregnancy, an adequate intake of these vitamins is a very real need, both for correct skeletal development and healthy tissue growth. ADEXOLIN—a balanced concentrate of vitamins A and D—meets this need precisely. Two forms are available: convenient capsules for adults, and liquid—free from unpleasant taste and odour—for youngsters.



ADEXOLIN

Trade mark

Liquid 12,000 units vitamin A and
2,000 units vitamin D per cc.
Bottles of 2 oz.



Capsules 6,000 units vitamin A and
1,000 units vitamin D
Bottles of 25 and 100

GLAXO LABORATORIES (S.A.) (PTY.) LTD., P.O. BOX 9875, JOHANNESBURG

Agents: M. & J. Pharmaceuticals (Pty.) Ltd., P.O. Box 784, Port Elizabeth

taken of the fact that many general practitioners have higher qualifications and/or long experience.

5. The mere fact that a specialist is entitled to charge a higher fee encourages the public to believe they are getting a better service.

6. The effect of the existence of the specialist register is that many medical students wish to become specialists for the sake of the greater prestige, higher fees and easier hours.

7. Legislation in this country has divided the profession into specialists and general practitioners, with different privileges and restrictions laid down by rule.

8. General practitioners have been ousted from appointments at all teaching hospitals, and are being progressively ousted from senior appointments in other Provincial hospitals.

9. Postgraduate education is tending to become exclusively concerned with the training of specialists, and thus the wider field of postgraduate education for general practitioners wishing to improve their knowledge is being neglected.

10. It is an ethical principle of the profession that a medical practitioner should not advertise himself for professional gain. There are members of the profession and of the public who construe the fact of registration of a speciality as an indication of the practitioner's skill or competence.

POINTS WHICH HAVE BEEN ADVANCED AGAINST A REGISTER OF CONSULTANTS WITHOUT A REGISTER OF SPECIALISTS

1. The consultant is dependent upon his medical colleagues for work, and until he is known it will be difficult for him to make a living.

Further, unless he has a hospital post, and these are limited, he cannot get known.

2. Many in the profession would not support the consultant asked for by the patient, and there would be diversion of work.

3. Many specialists who aspire to consultant status in due course, will not attain this if restricted to consultant practice.

4. The public would object to being denied a free choice of doctor.

5. It is an ethical principle in the profession that a medical practitioner should not advertise himself for professional gain. There are members of the profession and of the public who will construe the fact of registration as a consultant as an indication of the practitioner's skill or competence.

6. In view of the fact that a patient would not have direct access to a consultant, it would mean the payment of an extra fee to his general practitioner for the introduction.

POINTS WHICH HAVE BEEN ADVANCED IN FAVOUR OF A DUAL REGISTER, I.E. A REGISTER OF SPECIALISTS PLUS A REGISTER OF CONSULTANTS

The points in favour of a Dual Register are identical with those already outlined in 'Points which have been advanced in Favour of a Specialist Register' and 'Points which have been advanced in Favour of a Consultant Register without a Register of Specialists'. An additional point in favour of a Dual Register is:

It would be an advantage to the profession to know which medical practitioners practice as Consultants and which as Specialists.

POINTS WHICH HAVE BEEN ADVANCED AGAINST A DUAL REGISTER, I.E. A REGISTER OF SPECIALISTS PLUS A REGISTER OF CONSULTANTS

The points against a Dual Register are identical with those already outlined in 'Points which have been advanced against Statutory Registration of Specialists' and 'Points which have been advanced against a Register of Consultants without a Register of Specialists'. An additional point against a Dual Register is:

It would create difficulties for the medical practitioner who wishes to practice purely as a consultant, since he would have to compete with the practitioner registered as a Specialist, and as far as the general practitioner was concerned, it would not resolve the objection against a Specialist Register.

Om finansiële redes vind die algemene praktisyn dit dikwels onmoontlik om 'n voltydse aanstelling te aanvaar.

4. As gevolg van die statuêre registrasie van die spesialis, reken die publiek aan hom kennis en bevoegdheid toe wat na bewering ver bo die van die algemene praktisyn is, en die feit dat baie algemene praktisyns oor hoër kwalifikasies en/of goeie ondervinding beskik, word nie in ag geneem nie.

5. Enkel en alleen die feit dat 'n spesialis op hoër gelde geregtig is, sterk die publiek in hul mening dat hul 'n beter diens kry.

6. Die bestaan van 'n spesialisregister beïnvloed baie mediese studente wat ter wille van die groter prestige, hoër gelde en greefiker ure, spesialiste wil word.

7. Wetgewing het in hierdie land die professie verdeel in spesialis en algemene praktisyns met verskillende voorregte en beperkings wat deur reëls voorgeskryf word.

8. Algemene praktisyns is uit aanstellings in alle opleidings-hospitale verdring en word ook in toenemende mate uit senior aanstellings in ander Provinsiale hospitale verdring.

9. Die neiging bestaan dat nagraadse opleiding hoofsaaklik met die opleiding van spesialiste betrokke is ten koste van die groter gebied van nagraadse opleiding vir algemene praktisyns wat hul kennis wil verbeter.

10. Dit is 'n etiese beginsel van die professie dat 'n mediese praktisyn homself nie vir professionele voordeel mag adverteer nie. Daar is lede van die professie en van die publiek wat die registrasie van 'n spesialiteit as bewys van die praktisyn se bedreuenheid of bevoegdheid aanvaar.

ARGUMENTE WAT TEEN 'N REGISTER VAN KONSULTERENDE GENEESHERE SONDER 'N SPESIALISREGISTER GEMAAK IS

1. Die konsulerende geneesheer moet staatmaak op sy mediese kollegas vir ondersteuning en tot dat hy bekend is sal dit moeilik vir hom wees om 'n bestaan te maak. Tensy hy 'n hospitaal-betrekking beklee, en sulke betrekkings is beperk, kan hy nie bekend raak nie.

2. Baie lede van die professie sal nie die konsulerende geneesheer wat die pasiënt kies ondersteun nie en dit sal 'n onbevredigende toedrag van sake oplewer.

3. Baie spesialiste wat graag mettertyd die status van konsulerende geneesheer wil bekom sal nie daarin slaag nie indien hulle tot konsulerende praktyk beperk was.

4. Die publiek sal beswaar maak as hul vrye keuse van geneesheer ontnem word.

5. Dit is 'n etiese beginsel van die professie dat geeneen reklame vir homself kan maak waaruit hy professionele voordeel kan trek nie. Daar is lede van die professie en van die publiek wat die registrasie van 'n geneesheer as konsulerende arts as 'n aanwysing van die geneesheer se bedreuenheid of bevoegdheid sal beskou.

6. Met die oog op die feit dat 'n pasiënt nie direkte toegang tot 'n konsulerende geneesheer sal hê nie beteken dit dat die pasiënt ekstra betaling aan sy algemene geneesheer vir die intro-duksie moet maak.

ARGUMENTE WAT TEN GUNSTE VAN 'N TWEEVOLDIGE REGISTER GEOPPER IS, D.W.S. 'N REGISTER VAN SPESIALISTE PLUS 'N REGISTER VAN KONSULTERENDE GENEESHERE

Die argument ten gunste van 'n tweevoudige register is dieselfde as die wat reeds ten gunste van 'n spesialisregister en ten gunste van 'n register van konsulerende geneeshere sonder 'n spesialisregister uiteengesit is. Nog 'n mening ten gunste daarvan is: dat 'n tweevoudige register die professie in staat sal stel om te weet welke geneeshere as Spesialiste praktiseer en welke as Konsulerende Geneeshere.

ARGUMENTE WAT TEEN 'N TWEEVOLDIGE REGISTER D.W.S. 'N REGISTER VAN SPESIALISTE PLUS 'N REGISTER VAN KONSULTERENDE GENEESHERE GEOPPER IS.

Die argumente teen 'n tweevoudige register is dieselfde as die wat reeds teen die Statuêre registrasie van spesialiteite en 'n register van konsulerende geneeshere sonder 'n spesialisregister uiteengesit is.

Nog 'n argument teen 'n tweevoudige register is: dat dit sake sal bemoeilik vir die mediese praktisyn wat alleenlik as konsulerende geneesheer wil praktiseer, aangesien hy met die geneesheer wat as spesialis geregistreer is, moet meeding. So ver dit die algemene geneesheer aangaan, sal dit nie die beswaar teen 'n spesialisregister uit die weg ruim nie.

This is a Specimen Questionnaire only and must not be used for voting purposes.

THIS ISSUE IS OF SUCH GREAT IMPORTANCE TO THE FUTURE OF MEDICAL PRACTICE IN SOUTH AFRICA THAT THE FEDERAL COUNCIL TRUSTS THAT EVERY PRACTITIONER WILL CONSIDER IT HIS DUTY TO ANSWER THIS QUESTIONNAIRE.

Replies must be sent to:

**THE SECRETARY,
MEDICAL ASSOCIATION OF SOUTH AFRICA,
P.O. BOX 643,
CAPE TOWN.**

To arrive on or before Saturday, 4 September 1954

The Questionnaire has been drafted in a form which it is hoped will enable every practitioner to give clear-cut answers, "Yes" or "No", to the various questions, without qualification.

WHERE ANY ADDITIONAL REMARKS ARE INSERTED THE PAPER WILL NECESSARILY HAVE TO BE CONSIDERED AS SPOILED

A Are you in favour of a reversion to the system which existed prior to the introduction of the Specialist Register in 1938?

Answer "Yes" or "No".

IF THE ANSWER TO QUESTION "A" IS "YES", DO NOT ANSWER ANY OF THE QUESTIONS IN SECTIONS B AND C.

IF THE ANSWER IS "NO", ANSWER SECTIONS B AND C. **EVERYONE IS REQUESTED TO ANSWER QUESTION D**

B 1. Are you in favour of a Register of Specialists only?

Answer "Yes" or "No".

2. Are you in favour of a Register of Consultants only?

Answer "Yes" or "No".

3. Are you in favour of a Register of Specialists plus a Register of Consultants?

Answer "Yes" or "No".

If you have voted "Yes" to any of the questions B.1., B.2 or B.3, you are requested to indicate below whether you wish the Register or Registers for which you have voted to be statutory or voluntary. (A Statutory Register is one maintained by a body authorised so to do by the Government, for example as is done now by the South African Medical and Dental Council. A Voluntary Register is one maintained by any other body which takes upon itself the responsibility of maintaining such a Register, e.g. Medical Association or other voluntary body).

C (a) Are you in favour of a Statutory Register?

Answer "Yes" or "No".

(b) If you are not in favour of a Statutory Register, would you be in favour of a Voluntary Register maintained by the Medical Association of South Africa or some other voluntary body?

Answer "Yes" or "No".

D If the registration of Specialists is to continue in any form, whether statutory or voluntary, do you think that Specialists should be allowed to do domiciliary visiting other than in emergencies or in consultation with another practitioner?

Answer "Yes" or "No".

NAME
(In Blockletters)

SIGNATURE

Dit is net 'n voorbeeld van hoe die vraelys daaruit sal sien en moet nie vir stemoedoeleindes gebruik word nie.

AANGESIEN HIERDIE VRAAGSTUK VIR DIE TOEKOMS VAN DIE MEDIESE PRAKTYK IN SUID-AFRIKA VAN DIE ALLERGROOTSTE BELANG IS, VERTROU DIE FEDERALE RAAD DAT ELKE GENEESHEER DIT SY PLIG SAL AG OM HIERDIE VRAELYS TE BEANTWOORD.

Antwoorde moet gerig word aan:

**Die Sekretaris,
Mediese Vereniging van Suid-Afrika,
Posbus 643,
Kaapstad,**

en moet hom bereik voor of op Saterdag, 4 September 1954.

Die Vraelys is opgestel met die doel dat elke geneesheer sonder voorbehoud „Ja“ of „Nee“ op die verskillende vrae kan antwoord.

AS ADDISIONELE OPMERKINGS BYGEVOEG WORD SAL DIE VRAELYS NOODWENDIG AS BEDORWE BESKOU WORD.

A Is u ten gunste daarvan dat terugkeer moet word na die toestand wat bestaan het voordat die Spesialisregister in 1938 ingestel is?

Antwoord „Ja“ of „Nee“

INDIEN DIE ANTWOORD OP VRAAG „A“ „JA“ IS MOET U GEENEEN VAN DIE VRAE IN SEKSIE B EN C BEANTWOORD NIE.

INDIEN DIE ANTWOORD „NEE“ IS, BEANTWOORD SEKSIE B EN C. **ELKEEN WORD GEVRA OM VRAAG D TE BEANTWOORD**

B 1. Is u ten gunste van 'n register alleenlik van spesialiste?

Antwoord „Ja“ of „Nee“

2. Is u ten gunste van 'n register alleenlik van konsulerende geneesheer?

Antwoord „Ja“ of „Nee“

3. Is u ten gunste van 'n register van spesialiste plus 'n register van konsulerende geneesheer?

Antwoord „Ja“ of „Nee“

Indien u „Ja“ geantwoord het op enige van die vrae B.1, B.2 of B.3, word u versoek om hieronder aan te dui of u verlang dat die register of registers waarvoor u gestem het, statutêr of vrywillig moet wees. (‘n Statutêre Register is een wat deur 'n liggaam gehou word wat daartoe deur die Regering gemagtig is soos bv. nou deur die S.A. Geneeskundige en Tandheelkundige Raad gehou word.)

(‘n Vrywillige register is een wat deur enige ander liggaam gehou word wat dit op sigself geneem het om so 'n register te hou, bv. die Mediese Vereniging of ander vrywillige liggaam.)

C (a) Is u ten gunste van 'n Statutêre register?

Antwoord „Ja“ of „Nee“

(b) As u nie ten gunste van 'n statutêre register is nie, sou u ten gunste van 'n vrywillige register wees wat deur die Mediese Vereniging van Suid-Afrika of een of ander vrywillige liggaam gehou word?

Antwoord „Ja“ of „Nee“

D Indien die registrasie van spesialiste in enige vorm moet voortgaan, of dit statutêr of vrywillig is, dink u dat spesialiste behoort toegelaat te word om huisbesoekte, behalwe in nood-gevallen of in konsultasie met 'n ander geneesheer, af te lê?

Antwoord „Ja“ of „Nee“

Naam
(In Hooftletters)

Naamtekening

THE DOMICILIARY CARE OF SICK PERSONS AS PART OF A COMPREHENSIVE HEALTH AND MEDICAL CARE PROGRAMME

H. T. PHILLIPS, M.B., Ch.B., D.P.H.

and

HELEN D. COHN, R.N., R.M., M.P.H.

Institute of Family and Community Health, Union Health Department, Merebank, Durban

In the modern practice of public health with its broad approach to man in his environment, three important considerations are receiving increasing attention, viz.:

I. The value of team practice as opposed to individual specialist service.¹ The health team integrates the skills of different professions and maintains a continuous contact with the community it serves, its function being to provide a comprehensive programme of health and medical care.

II. The importance of treating the patient's environment in such a way as to mitigate the hazards to which he has been exposed so that a recurrence of his illness may be prevented.²

III. The possibility of disadvantages existing in institutional care from a psychological, social and economic point of view, and consequently the choice of home care when this is practicable.³

The purpose of this paper is to describe the domiciliary care of the sick by the Lamont Health Centre when these three considerations are incorporated in a family health and medical care programme.⁴

The team of this Health Centre is comprised of doctors, nurses and health educators engaged in a comprehensive health and medical care programme. The team's effectiveness depends on (a) its understanding of the underlying causes of ill-health in the Lamont community, and (b) the application of this knowledge in its programme.

The programme aims at improving the health of the community through the better use of such resources as income, housing, home gardens, food supplies, etc., as well as an intelligent use by the community of available health agencies. The Health Centre offers in addition to the health education programme, full medical, nursing and laboratory services in both curative and preventive care. The team aims to develop a relationship with the community which will stimulate and encourage the people to participate actively in the prevention of their own diseases and in the care of their own sick. Personal preventive services provided by the Health Centre team include maternal and child health care, communicable disease control and health examinations, as well as the care of the sick at the Centre and in their homes.

The Health Centre staff works in such a way that families receive their total service (whether preventive or curative, whether at home or at the Centre) by the same set of workers. Furthermore, the family nurses and health educators belong to the same ethnic and culture group as the families of their area and speak the

same language. These 2 factors encourage a close relationship between workers and people.

THE COMMUNITY BACKGROUND

Before describing the programme of domiciliary care of the sick—which is one aspect of the total programme—it would be as well to outline the background of the community and its major health problems.

The Lamont township commenced as a sub-economic native housing scheme on the outskirts of Durban in 1934. It has since expanded to its present size of 1,359 dwellings in mid-1953. With an average of 6 to each home, the total population is approximately 8,000 persons. The people are nearly 100% Bantu, with 70% of Zulu origin. Apart from occasional heathens they are all members of various Christian denominations.

Because the policy of the authorities is to allocate houses only to heads of legally-married families, domestic life is relatively stable in the township in comparison with that existing in the uncontrolled areas of Durban. Nevertheless there is considerable instability of family life as evidenced by the high incidence of alcoholism, delinquency, illegitimacy, desertion and unemployment. Additional problems arise as a result of frequent visits of kinsmen from the country seeking employment, shelter and medical care.

Nearly all the older inhabitants were born in rural tribal surroundings and they still consider their ancestral homes (where they pay their taxes) as their real homes, even though some of them have lived with their families in Lamont for as long as 18 years. All carry a heritage of tribal lore; some of their customs and beliefs are detrimental and others beneficial to their health. Because of the heterogeneous background, the extent to which tribal and western ideas and practices are mixed varies greatly from family to family.

MAIN HEALTH PROBLEMS

1. *Malnutrition:* Practically all the patients over the age of 2 years show clinical evidence of malnutrition. When this is due to faulty diet the reasons are not always due to poverty; for example, it is common to find families buying more expensive foods, e.g. patent infant preparations, when cheaper and more nourishing foods are available. Few appreciate the potentialities of home gardens as sources of food. Sometimes the malnutrition is due to chronic illness of the main breadwinner, often of a psychoneurotic nature, or due to the presence of infections and parasites. At times the large number of children is the important factor, many of them illegitimate, but all nevertheless to be fed.

2. *Infectious Diseases and Infestations:* Upper respiratory infections are common, often with otitis media as a complication. Tuberculosis is frequently observed, usually in the primary stage but too commonly in the more advanced pulmonary stage. Scabies and impetigo are frequent causes of ill-health and usually affect several members of a family at one time. Intestinal parasites are frequently found and reflect the low standard of sanitary habits.

3. *Syndromes Indicative of the Rapid Social Changes* which the population is undergoing—alcoholism, broken homes, delinquency, illegitimacy, venereal diseases—are common.

4. *The Use of Home or Folk Remedies* abounds. These practices are not always harmful and in fact do much to allay anxiety. Nevertheless, the use of *isinyanga*, witch doctors, herbalists and patent medicines often results in delay in obtaining efficacious treatment for such illnesses as pneumonia, enteritis and tuberculosis.

CARE OF THE SICK PATIENT

The majority of sick people are treated at the Health Centre. The team's knowledge of the home background of the patient assists to a very material degree in diagnosis and treatment.

While many patients can be treated at the Centre, others are confined to bed and visited by the Family Nurse and if necessary the doctor.

The decision to care for sick patients in their own home rather than refer them to hospital requires the fulfilment of certain criteria to which all members of the team contribute. These criteria include satisfaction that:

- (1) the procedures necessary for the efficient care of the particular patient can be carried out at home;
- (2) there is some suitable person in the home who can undertake the responsibility of nursing;
- (3) the patient constitutes no danger to the family, and will suffer no ill-effects from the presence of any other member of the family.

During 6 consecutive months in the year 1951 there were 108 cases who received domiciliary nursing care, all of which in the absence of this service, would have been referred to hospital for admission.

These patients were diagnosed as follows:

Bronchopneumonia (20 cases), amoebic dysentery (17 cases), lobar pneumonia (13 cases), pulmonary tuberculosis (7 cases awaiting hospital admission), P.U.O. (severe—6 cases), enteritis (severe—5 cases), congestive cardiac failure (4 cases), severe nutritional failure of infants (4 cases), cellulitis with osteitis (3 cases), severe pellagra, abortions, gonococcal arthritis, diabetes (for stabilization), and severe bacillary dysentery (2 cases of each), ascites, pelvic cellulitis, tuberculous peritonitis (discharged from hospital), rheumatoid arthritis, acute rheumatic fever, infantile pellagra, quinsy, puerperal sepsis, thrombo-phlebitis, auricular fibrillation, cerebral thrombosis, hypertensive encephalopathy, hydrocephalus, acute salpingitis, scarlet fever, acute cholecystitis, severe hysteria, lung abscess, extensive burns (one case of each).

CASE REPORT AND DISCUSSION

The method in which service applied to one of the 17 cases of amoebiasis is given as an illustration of the programme of domiciliary care of the sick. The patient's family file has been summarized for this purpose.

Rebecca, aged 18 years, was diagnosed by the Health Centre doctor (Dr. A.) on 15 May 1951 as having acute amoebic dysentery. The following treatment was ordered:

- (1) rest in bed for 2 weeks;
- (2) medications: a course of 10 daily injections of emetine hydrochloride; Amoebaquin and Sulphathalazole in the usually recommended doses; and
- (3) a bland high protein diet.

It was decided that she should be nursed in her own home and that the Family Nurse (Nurse B.) should visit her daily for 10 days and make regular reports to Dr. A. Unless her progress called for any change in treatment the patient should return to the Health Centre after a period of 2 weeks for re-examination by Dr. A.

Home Background: This family had been known to the Health Centre for 3 years. Rebecca was the eldest daughter. Her parents were both employed by the day in Durban, one in a store and the other in domestic service, and they returned home to Lamont at night. Rebecca had 2 younger sisters both at day school in Lamont. Her mother's unmarried sister, Martha, with her illegitimate child of 4 years, lived in the same house and they were at home during the day. Rebecca herself worked in a factory where she was responsible for making tea, washing-up, etc., for the office staff.

Thus 4 adults, 2 school-age children and a pre-school-age child occupied the house which was a 3-roomed cottage with a small yard. Although its occupants were overcrowded, the house was clean and fairly well kept but the yard was neglected and dirty.

Previous Health Centre Care: All members of the family except the father had attended the Centre for health examinations; the father did not wish to make use of the service. Findings at these examinations called for treatment of helminths and scabies in various members of the family, which was carried out by the Family Nurse (Nurse B.) under instructions from Dr. A.

Martha and her baby had been fairly regular attenders at the session organised by Nurse B. for mothers and babies of this area.

The baby and the two school-children of the family had been vaccinated by Nurse B. and immunized against diphtheria and whooping cough. She had also arranged for periodic tuberculin patch testing and chest X-rays. No indication of tuberculosis was found in this family.

During the past 3 years various illnesses had occurred and had been treated at the Centre or at home by Dr. A. and Nurse B. Both the school-children had had measles; Martha's child had suffered from bronchopneumonia and several attacks of coryza. Rebecca herself had aborted a 3 months' foetus a year previously.

It should be appreciated that all aspects of this service, whether of a curative or preventive nature, had been carried out entirely by Dr. A. and Nurse B., who were the family doctor and family nurse respectively.

Health Educators, who are the third category of personnel employed in the Health Centre team, have carried out their programme of health education in this family mainly with regard to domestic hygiene and food habits. The total Health Centre programme for this family is based on the knowledge of all team members, and in this respect Health Educators contribute the results of their investigations into the family's way of life, as well as the family's place in the community. It was with this background of knowledge of the family as well as the established relationship with each member, that the Family Nurse (Nurse B.) proceeded to carry out the treatment of Rebecca's amoebic dysentery.

In many respects the care of a patient at home is no different from the care given in hospital. From the point of view of the disease and its treatment, the patient—whether at home or at hospital—receives the required medications, diet, rest in bed and the nursing care such as bathing, toilet and other procedures designed for the patient's comfort.

In the home, however, many of these procedures have to be carried out by a member of the household. The success or failure of a home nursing programme may

depend to a large degree upon the suitability of the family member undertaking this task.

Martha, who was well known to Nurse B., was the obvious choice for Rebecca's nursing care, for the care of her own child as well as the daily housework kept her at home all day. Had this not been so, it might have been necessary for Rebecca's mother to stay away from work. The economic disadvantage of this, however, may again have reversed this decision in favour of hospitalization.

The Family Nurse discussed Rebecca's treatment with Martha and explained the responsibility she would carry as 'Home Nurse'. On her arrival at the home each day she checked with Martha on such items as the patient's sleep, bowel actions, diet, and appetite, the administration of 4-hourly drugs, etc. Martha learnt to take the temperature and pulse and gained good insight into signs of progress, e.g., better sleep at night and less diarrhoea, and she made her reports accordingly.

Treatment of Environment: Nurse B. discussed with both Martha and the patient the cause and aetiology of the disease and its mode of spread. In addition to conscientious care of her patient, Martha was encouraged to prevent the spread of the disease when she realized the hazard to members of the family and more particularly to her own child. The possible course of this infection, the importance of hand washing and controlled disposal of excreta, and the protection of cooked and uncooked food, all of which have been discussed with Lamont families, became a focus of increased attention, and an attitude to disease and its prevention was developed through actual application of this knowledge.

It is a matter worthy of serious consideration that this experience is lost to the family whose patient goes to hospital, although on the other hand it is just such a family that would benefit from such experience.

Because Martha and Rebecca now understood that the organism causing the disease could be detected in the excreta, it was not difficult to procure stool specimens from each member of the family. These were collected by Martha and given to the Family Nurse for transfer to the Health Centre Laboratory.

The diet arranged for Rebecca was based both on food available to the family and on nutritional requirements related to her condition. The relative values of foods were thus discussed with Martha, as they referred not only to Rebecca but to all members of the family. In order to improve Rebecca's diet, the value of meat, vegetables, milk and milk products was emphasized, and—to the extent of what the family could afford—their buying and eating habits were modified.

Many aspects of home life related to Rebecca's progress were considered and Martha's home nursing had a marked effect on the family's general standard of living.

Meanwhile, Rebecca herself—dependant on the Family Nurse for her daily injection and daily assessment of her progress—was even more dependant upon Martha, a member of her own family, for the countless small services required by a bed-ridden person. The effect of such interdependence of family members at time of illness is undoubtedly of a permanent nature, as it is this type of experience which strengthens family bonds.

Furthermore, the impression gained by the Family Nurse was that Rebecca was comfortable, relaxed, and responding well to treatment. In this particular case there was no doubt that she was happier in her own home than she would have been in hospital.

According to our records we were able to assess the cost of treating this case at 4s. 4d. per day for 12 days. Although the patient paid no actual fee for treatment (the costs of which are borne by the taxpayer), her family made full contribution to her care in respect of service, food and accommodation.

Rehabilitation: It is not unusual for the nurse to detect signs of maladjustment to the working situation in the form of reluctance to return to work when physically fit. This requires careful handling, and the doctor and nurse who have treated the patient must assume responsibility for procedures necessary for his rehabilitation.

For the purposes of completing this case report the authors visited Rebecca in January 1954 (3 years after she had suffered from the disease). She was at home feeding her 2-weeks-old baby.

We explained to her that we were interested in knowing whether or not the teaching given to her by the Family Nurse had been effective, and asked her therefore to tell us what she remembered of the cause and mode of spread of amoebic dysentery.

Rebecca's home language is Zulu, but she gave us the following facts in English:

(1) In rural areas streams and springs become polluted by people who do not have proper latrines. When people drink this water they become infected. In town however where there are latrines, the disease is spread by (a) using them carelessly, for example, by not flushing the pan after use; and (b) by the infected person not washing his hands before preparing food.

(2) Food should be kept covered and protected from flies which may infect it.

(3) The germ is found in the stool. When Rebecca had been ill, stool specimens of all members of her family were tested for the germ.

Rebecca did not remember that her diet had been supplemented with dried skimmed milk, but she did remember that she was confined to bed for the 2 weeks when she received injections.

Rebecca is a 21-year-old African girl of only 5 years schooling. She has had no subsequent experience of amoebiasis except for the routine examination of her stool for several months after her recovery. She has worked continuously in her previous employment until one month before the birth of her baby. Her knowledge of the cause of amoebic dysentery should undoubtedly contribute to the general standard of hygiene in her home.

DISCUSSION

It will be seen that the Lamont Health Centre has given particular attention in its daily practice to the considerations stated in the introduction to this paper.

(1) **Team Practice:** A team of health workers provides a comprehensive health and medical care programme, a part of which is the domiciliary care of sick persons. The members of the team develop a growing knowledge of the families under their care both in health and in disease. They are aware of the physical, psychological and social conditions of the lives of these families. Each member of the team has his own particular part to play in the modification of these conditions by education as well as by clinical corrective procedures over a prolonged period. When illness occurs in a member of a family, it is seen as a calamity of greater or lesser degree within the context of the team's knowledge of the family. Frequently illness helps to throw additional light on the lives and interrelationships of the family members and this knowledge increases the team's overall understanding of the family's history and development.

In the domiciliary care of sick persons the main burden is carried by the Family Nurse. Her hospital training and experience are supplemented when she enters the Health Centre service by a course of training in the principles and techniques of family practice.⁶ Not only does she now function as a member of the team, but she provides a comprehensive preventive and curative nursing service.

(2) **Treatment of the Environment:** The Health Centre team aims at treating both the patient and his environment. In the presence of illness there is often strong motivation for learning about the causes of ill-health and for changing one's habits. It will be seen that the patients' diagnoses listed above include cases requiring a wide range of skills and which provide a variety of opportunities for educating the family in the aetiology of disease, thereby treating the environment.

The Family Nurse in the home sees her patient not in the hospital surroundings, which are temporary, foreign and unrelated to the pathogenesis of his disease, but rather in that very environment which gave rise to his

physical and emotional condition.⁶ Thus by her observation and assessment of the patient in relation to his family and his home, she is able to modify or exploit available resources to his best advantage. Usually that member of the family who is to take charge of the patient under the supervision of the Family Nurse is receptive to an educational experience which raises the family's standard of health both at that time and for the future.⁷

In the care of nutritional diseases, the person in charge of the patient learns something of the treatment of the case and the prevention of recurrence by dietary means. In the case of surgical and infective conditions she can learn much about the sources of infection and the prevention of its spread. In the care of chronic cases there is scope for occupational therapy and the better care of the aged sick. In all cases it is essential for this family member in her intimate association with the patient to learn to observe his progress and determine which factors are advantageous to his recovery, and which are not so.

Concurrently with the patient's treatment, the home itself receives treatment. Recovery is not complete until or unless his home is such that his health can be maintained at the highest possible level. While the patient himself is the main focus of attention, all members of the family benefit from the improved standard of health in his home.

(3) *Psychological, Social and Economic Advantages of Home Care:* This aspect has received considerable attention.⁸ Recent studies demonstrate the traumatic effects on a child when removed from its home environment to an institution.^{9, 10, 11} There are emotional advantages to the sick child not only in remaining in its own home but also in being nursed by its own mother.

Treatment of patients in their own homes is easier where those tensions associated with a strange place are not superimposed upon his illness, or where the patient is not subjected to the procedures of a culture different from his own. This applies particularly to people who are strongly influenced by witchcraft and magical beliefs. Their resistance to hospital is very often associated with fear of sleeping among strangers as well as fear of witnessing suffering and death in others.

Emotional tensions pertaining to the patient's own home which may seriously affect his recovery are often clearly perceptible to the Family Nurse. In hospital however,—removed from the source of their tensions—these important factors may be overlooked. Complete rehabilitation is therefore often easier when the patient has not been removed from his own environment. He is not subjected to the emotional burden of adjustment to hospital life on admission, nor again to the readjustment to his home on discharge. The stages of his recovery proceed more smoothly in his own home, where members of his family and the Family Nurse are consciously encouraging him to increase his range of activities in order to regain his place in his family and work life.¹²

Another advantage of domiciliary care of sick people is the relatively low cost of such a service. The estimated cost including staff salaries, drugs, transport and laboratory investigations for treating the case of amoebic dysentery described above was 4s. 4d. per day. The daily costs of treating other typical cases were: broncho-

pneumonia 3s. 2d., nutritional oedema 2s. 8d., pyrexia of unknown origin 2s. 9d. and congestive cardiac failure 1s. 5d.

In the Montefiore Hospital's home-care programme Bluestone¹³ found that 'an analysis of cost to the hospital indicates that home care is about $\frac{1}{4}$ of the cost of maintaining the same patient in a hospital bed'. Although we were unable to make accurate comparisons with local hospitals, we estimated the cost of home care to be about 12%—30% of hospital cost, depending upon the type of case.

The taxpayer is not called upon to pay for the accommodation, feeding and clothing of patients when treated at home. It is considered also that there are fewer relapses and recurrences in cases treated in this manner. It has not been possible to estimate the saving resulting from preventive measures, early treatment and avoidance of recurrence resulting from such a comprehensive health and medical service.

It should be stressed that while the service provided by the Lamont Health Centre is given free, the use of their own resources by the people is an essential part of the educational process intrinsically necessary for an improved standard of living.

'When Service does for men those things which Education could enable him to do for himself he is weakened'.¹⁴ This attitude not only prevents an unhealthy dependence upon the personnel of a free agency but actually achieves the self-reliance of an enlightened community.

SUMMARY

(1) Three considerations in the modern practice of public health are: (1) The value of team practice; (2) the treatment of the environment as an essential part of the treatment of a patient; and (3) the desirability of home care of sick persons where this has psychological, social and economic advantages over hospitalization.

(2) Attention is given to these considerations by the staff of the Lamont Health Centre in its total practice of family health and medical care. The functions of the Health Centre team are explained and a brief outline of the Lamont community and its major health problems is given.

(3) One aspect of this service is the domiciliary care of sick persons. Patients over a period of 6 months, who in the absence of the Family Nursing Service would have required hospitalization, are listed. The service is illustrated by a report on a case of amoebic dysentery appearing on this list.

(4) The advantages of the service are discussed in relation to: (1) the recovery and rehabilitation of the patient; (2) the educational experience to the patient and his family; (3) the economic saving both to the taxpayer by the utilization of family resources, and to the family by raising its general standard of health. (The total expenditure by the Health Centre on a typical case of amoebic dysentery was estimated to be only 4s. 4d. per day. It was estimated that domiciliary treatment cost only 12-30% of the cost in hospital, depending on the type of case being treated); and, finally, (4) self-reliance



friend of man....

In man's constant fight against disease medical research is his closest friend. The discovery and synthesis of Chloromycetin® in the Parke-Davis laboratories ranks high in the achievements of post-war medical science. Chloromycetin's wide spectrum of activity and the unique facility with which oral doses are absorbed give this antibiotic a vital role in the treatment of disease. The variety of forms available provide that flexibility of treatment essential for varying clinical conditions. Chloromycetin, the first synthetic antibiotic, is indeed a friend of man.

CHLOROMYCETIN

® Registered Trade Mark

*the first
synthetic antibiotic*



P.D. & Co. (Pty.) Ltd., P.O. Box 9971, Johannesburg subsidiary of Parke Davis & Co., Detroit, Mich.
Distributors: Lennon Ltd., P.O. Box 8389, Johannesburg and branches.



PREVENTION IS BETTER THAN CURE

- **PROPHYLAXIS:** When disregard of warning signals such as fatigue, loss of appetite and general debility, invites respiratory infections, then Waterbury's Compound will indeed prove timely.
- **GENERAL THERAPY:** Waterbury's Compound will stimulate appetite, help to improve the blood picture and heighten that rather indefinable state known as a sense of well-being.
- **THE INTRACTABLE COUGH:** The creosote and guaiacol in Waterbury's Compound will prove a therapeutic boon. The cough soon loosens and gradually diminishes in frequency.
- **CONVALESCENCE:** Convalescence is still a few stages removed from complete recovery. It is best to continue prescription of Waterbury's Compound until danger of relapse is past.

WILLIAM R. WARNER & CO. (PTY.) LTD.,
6-10 Searle Street, Cape Town.

**WATERBURY'S
COMPOUND**



That Disturbed Night —

The nocturnal paroxysm which keeps your patient with a cough awake often disturbs the sleep of the rest of the household.

MELANTOL Cough Mixture stops your patient's cough and peace will once again reign.

Each fluid drachm of MELANTOL contains Sodium Acid Citrate 280 mg., Mephensin 52 mg., Codein Phosphate 3.5 mg., Pyrilamine Maleate 5.2 mg. These ingredients are incorporated in a syrup demulcent base with a pleasant flavour. Alcohol content 15%

Descriptive literature available from



SAPHAR LABORATORIES LIMITED • P.O. BOX 256, JOHANNESBURG
P.O. BOX 568, CAPE TOWN • P.O. BOX 2383, DURBAN • P.O. BOX 789, PORT ELIZABETH.



• **ASTHMA**
• **BRONCHITIS**
• **EMPHYSEMA**

are rapidly relieved by the

Bronchovydrin

**INHALATION
THERAPY**



DRITAX HAND INHALER

Available with or
without a Face Mask

RIDDELL

Available in cartoned bottles of 12.5 gm.

SUPER PAG is a large
table model and can be
supplied with single or
double bulb, also with
bakelite stand.

2



SUPER PAG HAND INHALER

RIDDELL INHALERS deliver a fine degree of dry atomisation in the
region of 20 microns, which is absorbed by the alveoli with extreme rapidity
affording relief to an ASTHMA attack within the matter of seconds and yet
is very easily administered by the patient without inconvenience.

Please write for technical data.

PNEUMOSTAT ELECTRIC INHALER is suitable for
AC-DC of 90-110 volts or 200-250 volts, and is supplied
complete with two SUPER PAG Inhalers either of which
is brought into use by a two-way tap

3



PNEUMOSTAT ELECTRIC INHALER

Sole
Manufacturers

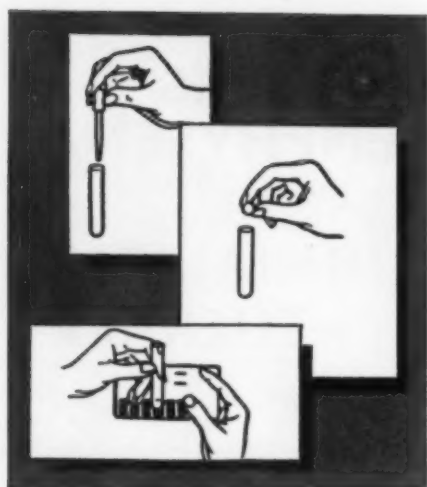
RIDDELL PRODUCTS LIMITED

RIDDELL HOUSE, 10-14, DUNBRIDGE STREET, LONDON E.2.

South African Representatives: FASSETT & JOHNSON LTD., 72 SMITH STREET, DURBAN.

Phone: 2-9521

Please Support Our Advertisers — Ondersteun Asseblief Ons Adverteerders



CLINITEST

(BRAND)

URINE-SUGAR DETECTION

SIMPLE • SWIFT • DIRECT

Everything needed for reliable urine-sugar testing in one set! Each *Clinitest* Reagent Tablet contained in the set contains all reagents required for copper reduction test. No external heating necessary—tablets generate heat on dissolving. To perform test, simply drop one tablet into test tube containing diluted urine. Wait for reaction, then compare with color scale. Tablet refill available from your Chemist. Ideal for doctor, patient or laboratory.

Contact our
representative for
literature, today!



AMES COMPANY, INC.
Elkhart, Indiana, U. S. A.

EXCLUSIVE DISTRIBUTOR:

Professional Pharmaceuticals Ltd.
Campaign House
19 Ramsey Street
P.O. Box 2515
Johannesburg
South Africa

It is the experience of medical
men all over the World that



Hearing Aids can be pre-
scribed with confidence



WESTDENE PRODUCTS (PTY.) LIMITED

2nd Floor, Essanby House, Johannesburg.
67 National Mutual Buildings, Durban.

Write for name of nearest dealer

ANAESTHETIC ETHER

Manufactured by

THE NATAL CANE BY-PRODUCTS LTD.

OF MEREBANK

● Guaranteed to conform to the requirements of the 1948 British Pharmacopoeia and the Specification of the South African Bureau of Standards. Equal to the finest imported Ether.

● In cases, each containing 12 x 1 lb. Amber Coloured Bottles, similar to those used in Europe.

For further information please write to the selling Agents

G. C. SMITH & CO. LTD.

301 Smith Street, P.O. Box 43, Durban

Bert Mendelsohn (Pty.) Ltd.,
P.O. Box 565, Johannesburg.

C. G. Smith & Co., Ltd.,
P.O. Box 1314, Cape Town.

Courlanders' Agencies
P.O. Box 352, East London.

on the part of the community is engendered by this type of service.

Thanks are due to the Secretary for Health for the Union of South Africa for permission to publish this paper.

REFERENCES

1. President's Commission on the Health Needs of the Nation. 'Building America's Health', vol. I, p. 3. U.S. Govt. Printing Office, 1952.
2. Gordon, J. E. (1952): 'The Newer Epidemiology' in *Public Health Lectures*. Boston, Mass.: Unitarian Services Committee Inc.
3. Bluestone, E. M.: Survey, March 1949.
4. Kark, S. L.: 'Health Centre Practice—A South African Experiment in Family Health and Medical Care' in *Social Medicine*, ed. Cluver, E. H. (1951). Johannesburg: Central News Agency.
5. *Ibid.* (1950): S. Afr. Nursing J., 16, 8.
6. Cherkasky, M. (1945): Amer. J. Publ. Hlth., 39, 163.
7. Cohn, Helen D. (1950): Health Education J., 8, 18.
8. Bluestone, E. M.: Mod. Hosp., August 1949.
9. Bakwin, H. (1949): J. Pediat., 35, 512.
10. Boulby, J. (1951): *Maternal Care and Mental Health*. Wld. Hlth. Org. Monograph Ser.
11. Steuart, G. W. (1952): S. Afr. Med. J., 26, 472.
12. Field, M. and Schless, B.: J. Social Case Work, March 1948.
13. Bluestone, E. M.: Survey, April 1948.
14. Turner, C. E. (1950): 'Health Education Yesterday and Today', in *Biological Foundations of Health Education*. New York: Columbia University Press.

NATIONAL GENERAL PRACTITIONERS' GROUP: AMENDED CONSTITUTION

In the *Journal* of 12 June 1954 (28, 504), the proposed amended constitution was published as it was to be submitted to the Annual General Meeting of the National General Practitioners' Group to be held in Port Elizabeth on 25 June 1954.

At this meeting the proposed constitution was adopted as printed, subject to the following changes:

Clause IV. Control. Substitute for paragraph 7 the following:

7. The National Committee shall be elected by branches or sections, each branch having 1 (one) member for the first 50 (fifty) and thereafter 1 (one) member for every additional 100 (hundred) or the major portion thereof.

Clause V. Meeting. Substitute for paragraph 11 the following:

11. General Meetings of the Group may be held from time to time and shall be called by the Executive Committee on the written request of 40 (forty) members of the Group. Voting by proxy shall follow as nearly as is material the form prescribed in the By-Laws of the Association.

Clause VII. Organization. Substitute for paragraph 16 the following:

16. Reports of local action taken shall be submitted within 14 (fourteen) days by the Honorary Secretary/Treasurer of the branch or section to the Honorary Secretary/Treasurer of the Group.

PASSING EVENTS : IN DIE VERBYGAAN

Cape Town Paediatric Group. A meeting of the above group will be held in the E Floor Lecture Theatre, Groote Schuur Hospital, on 6 August 1954, commencing at 8.15 p.m.

Dr. N. van der Merwe will speak on: 'Some Clinical and Social Problems Rising out of the Medical Inspection of Schools'. This talk will include many other interesting matters concerning the diseases, developments and health of the school child and its parents.

* * *

Union Department of Health Bulletin. Report for the 7 days ended Thursday, 1 July 1954.

Plague, Smallpox: Nil.

Typhus Fever, Cape Province. Two (2) Native cases in the Zibadla and Ngqwarra locations in Mqanduli district. Diagnosis of both cases confirmed by laboratory tests.

No further cases have been reported from the Idutywa district since the notification in Bulletin No. 22 of the 3rd June 1954. This area is now regarded as free from infection. *Natal.* One (1) Native case in the Harding district. Diagnosis confirmed by laboratory tests.

Epidemic Diseases in other Countries:

Plague: Nil.

Cholera in Chalna, Chittagong, Dacca (Pakistan); Calcutta (India).

Smallpox in Mogadiscio (Somalia); Karachi, Lahore (Pakistan); Bombay, Calcutta, Cochin, Delhi, Jodhpur, Kanpur, Madras (India); Hanoi, Hué, Saigon-Cholon (Viet-Nam); Phnom-Penh (Cambodia).

Typhus Fever in Benghazi (Libya).

* * *

Third International Congress of Nutrition. Under the auspices of the International Union of Nutritional Sciences the Third Inter-

national Congress of Nutrition is to be held at Amsterdam on 13-17 September 1954. It is intended to hold sessions devoted to a discussion of the following themes, among others: 'Overnutrition and Disease', 'Nutrition of Farm Animals', 'The Protein Element in Nutrition', 'Human versus Cows' Milk', 'Kwashiorkor', 'Parenteral Nutrition', 'Psychological Aspects of Nutrition', 'Non-Nutrient Foreign Chemical Substances in Foods (Intentional Additives)', 'Non-Nutrient Foreign Chemical Substances in Foods (Unintentional Additives)'. Full details of the Congress may be obtained from the Congress Office, J. D. Meijerplein 3, Amsterdam (C), Holland.

* * *

Dr. Neville Sacks, son of Dr. and Mrs. I. Sacks of Bloemfontein, who has been engaged on research work on the permeability of the blood vessels of the brain after fat embolism, has been appointed Registrar in the Medical Wards of the Royal Infirmary, Aberdeen.

* * *

Research Fellowships of the International Children's Centre. A number of fellowships for the academic year 1954-55 will be available for research workers who may wish to work at the Laboratories of the International Children's Centre, Paris.

At present the programme of research of the Centre is essentially connected with problems of anti-tuberculosis vaccination and antipertussis immunization.

The grants amount to 60.000 French francs per month. Travelling expenses from their residence to Paris will have to be borne by the research fellows.

Research workers who wish to apply for a fellowship are requested to send their application together with their curriculum vitae, record of previous work and testimonials of their chiefs of service to Professor Bugnard, International Children's Centre, Chateau de Longchamp, Paris 16^e.

BOOKREVIEWS : BOEKRESENSIES

CURATIVE HYPNOSIS

Curative Hypnosis. By Miscellaneous Authors. Edited by Raphael H. Rhodes. (Pp. 274+xiv. 17s. 6d.) London: Elek Books Limited 1953.

Contents: 1. Hypnosis: What it is and What it Does. 2. Hypnosis in Reconditioning. 3. Hypnosis and Alcoholism. 4. Hypnotic Control of Menstrual Pain. 5. Hypnotherapy for Children. 6. Hypnosis in Obstetrics. 7. Hypnosis and Suggestion in Obstetrics. 8. Hypnosis in Gynecologic Disorders. 9. Hypnotic Treatment of a Case of Acute Hysterical Depression. 10. Hypnotic Psychotherapy. 11. Induced Hypnagogic Reverses for the Recovery of Repressed Data. 12. Hypnotic Relaxation and Analysis. 13. Hypno-analysis. 14. Will Hypnotism Revolutionize Medicine? 15. Hypnotherapy for Voice and Speech Disorders. 16. Autohypnosis and Habit Control. 17. Self-Taught Autohypnosis for Insomnia and Obesity. Notes and References. Contributors. Index.

As more attention is paid to the psychosomatic aspect of medicine and the need for mental adjustment is more evident, so hypnosis as an aid to mental cure will become more obvious.

This masterly book, in which 12 leading physicians and psychologists discuss cures brought about by hypnosis, does a great deal to open this subject for the average practitioner. Case histories are described, as are the methods employed on various subjects. The articles explain how hypnosis is conducive to rapid psychotherapy and how cures are effected by its use in a fraction of the time needed for other forms of treatment.

The new technique of self-taught autohypnosis is described and its use in cases of insomnia and obesity are explained. The Editor, Dr. Raphael H. Rhodes, is to be congratulated on a useful contribution to the literature on this subject, but this is only to be expected of an author of his calibre.

A.H.T.

SYNOPSIS OF ANAESTHESIA

A Synopsis of Anaesthesia. By J. Alfred Lee, M.R.C.S., L.R.C.P., M.M.S.A., D.A., F.F.A.R.C.S. Third Edition. (Pp. 483, with 72 illustrations. 21s.) Bristol: John Wright & Sons, Limited. 1953.

Contents: 1. Notes on the History of Anaesthesia. 2. Some Anatomical and Physiological Notes. 3. Pre-Anaesthetic Care and Preparation. 4. The Pharmacology of Drugs Used for Pre-Operative and Post-Operative Medication. 5. Inhalation Anaesthesia. 6. Agents for Inhalation Anaesthesia. 7. The Closed Circuit; Cyclopropane; Controlled Respiration. 8. Nitrous Oxide Anaesthesia. 9. Accidents of Inhalation Anaesthesia and How to Treat Them. 10. Gases Used in Association with Anaesthesia. 11. Endotracheal Anaesthesia. 12. Rectal Anaesthesia—Basal Narcosis. 13. Intravenous Anaesthesia. 14. Anaesthetics. 15. Spinal Anaesthesia. 16. Regional Anaesthesia. 17. The Use of Muscle Relaxants in Anaesthesia. 18. Refrigeration Analgesia; Electrical Anaesthesia. 19. Choice of Anaesthesia, as Influenced by Type of Operation. 20. Choice of Anaesthetic Agents and Methods as Influenced by General Condition of Patient. 21. Shock. 22. Anaesthesia in Thoracic Surgery. 23. The Complications and Sequelae of Anaesthesia. 24. Production of Ischaemia during Operations. 25. Explosion Risks in Anaesthesia. 26. Management of the Unconscious Patient. 27. Anaesthetic Records. 28. The Anaesthetic Out-Patient Clinic. 29. Anaesthesia and Analgesia in Labour. 30. Therapeutic Aspects of Anaesthesia. 31. Post-Operative Recovery Room. Appendix. Index.

The third edition of this book is a true and full synopsis of modern anaesthesia. The author has evidently devoted much time and exercised great care in the preparation of this book. It will hold its own as a classic in the synopsis series of this well-known firm of publishers.

This volume of 483 pages covers the whole field of modern anaesthesia and analgesia. The only omission is a description of hypothermia or hibernation anaesthesia which is not mentioned in it. Apart from this, nothing of importance is omitted. The information it conveys is accurate and up-to-date. It is written in an easy style which makes reading a pleasure.

The theoretical sections dealing with physiology and pharmacology are models of lucidity, whilst the practical procedures and many techniques are excellently described in sufficient detail to make their application easy.

This synopsis clearly shows what a vast subject anaesthesia is today. Information scattered throughout numerous publications is brought together in this volume and conveniently abridged, and the references given. An excellent index enhances the usefulness of the book. It is a trustworthy guide, brimful of sound advice.

I have every confidence in recommending this synopsis to all those who are interested in the practise of anaesthesia. To the younger anaesthetists who are preparing for higher examination in this speciality it will be a veritable boon for rapid revision and a bird's-eye-view of the whole subject.

H.B.

SURGICAL PATHOLOGY

Surgical Pathology. By Lauren V. Ackerman, M.D. (Pp. 836, with 913 illustrations. £6 3s. 3d.) St. Louis: The C. V. Mosby Company. 1953.

Contents: 1. Introduction. 2. Skin. 3. Oral Cavity. 4. Mandible and Maxilla. 5. Respiratory Tract. 6. Mediastinum. 7. Parathyroid. 8. Thyroid. 9. Gastrointestinal Tract. 10. The Major and Minor Salivary Glands. 11. Liver. 12. Gall Bladder. 13. Pancreas and Periapillary Region. 14. Adrenal Gland. 15. Genitourinary Tract. 16. Male Reproductive System. 17. Female Reproductive System. 18. Breast. 19. Lymph Nodes. 20. Spleen. 21. Bone and Joint. 22. Soft Tissues. 23. Peritoneum and Retroperitoneum. 24. Vessels. 25. Central Nervous System. Index.

There has been something of a spate of books on surgical pathology in the last few years, particularly from the U.S.A., characterised by lavish illustrations and paper, printing and binding of high quality, but accompanied by a text which was often unhelpful or inadequate. Ackerman's *Surgical Pathology* resembles its predecessors and contemporaries in its illustrations and make-up, but stands head and shoulders above most of them in that the text in quantity and quality is of an equally high standard.

It is not intended as a substitute for a text book of pathology, its aim is to be supplementary. The book has throughout a strong practical tone, and is based largely on the author's extensive experience. The presentation is on a regional basis, as in most text books on surgical pathology, but few commence each section as Ackerman does by a discussion on the regional evaluation of rapid frozen sections and of exfoliative cytology. The surgeon who would like a rapid frozen section on a nodule in the thyroid will here learn why such a procedure is not likely to be helpful in diagnosis, though it may be of great value in other situations.

Ackerman is a practical slumper and not a splitter in classification, and his opinion that the commonest carcinoma of the stomach (60-80%) is of no specific type may be surprising to many readers, but is in accordance with the reviewer's experience. Debateable matters are adequately discussed, and the author's own opinions on these are mentioned but not unduly stressed.

The illustrations are abundant, well chosen and reproduced and there is an extensive bibliography at the end of each section, mainly to recent work in English, but not exclusively American. Misprints are few, though the substitution of abdomen for adenoma on page 328 is repeated on page 329.

Ackerman's *Surgical Pathology* can be strongly recommended to surgeons and pathologists alike. It is full of the data and opinions desired by both, and while there may be more elaborate books on this subject, one cannot think of a more practical, more helpful or sounder one than this.

J.G.T.

THORACIC SURGERY

Thoracic Surgery. By Richard H. Sweet, M.D. (Pp. 381 + xxv with 159 illustrations. Second edition. \$10.00.) Philadelphia and London: W. B. Saunders Company. 1954.

Contents: I. Surgical Anatomy of the Thorax. 1. The Thoracic Wall. 2. The Mediastinum. 3. The Pleura. 4. The Lungs. 5. The Diaphragm. II. General Technical Considerations. 6. Anesthesia. 7. Administration of Intravenous Infusions and Transfusions of Blood. 8. Details of General Operative Technique. 9. Suture Material Used in Thoracic Surgery. 10. Instruments Required for Thoracic Surgery. III. Thoracic Incisions. 11. Minor Thoracotomy Incisions. 12. Major Thoracotomy Incisions. IV. Operations on the Thoracic Wall. 13. Superficial Structures. 14. The Sternum. 15. Ribs and Costal Cartilages. V. Operations Concerning the Pleural Cavity. 16. The Management of Accumulations of Fluid in the Pleural Cavity. 17. Management of Accumulations of Air in the Pleural Cavity. VI. Operations on the Lung. 18. Drainage of Lung Abscess. 19. Extirpation of Parts or All of the Lung. 20. Special Procedures. VII. Operations Within the Mediastinum. 21. Introductory Considerations. 22. Drainage of Mediastinal Abscess; Posterior Mediastinotomy. 23. Excision of Primary Tumours. 24. Thyrectomy. 25. Operations on the Pericardium and Pericardial Cavity. V. Operations Concerning the Pleural Cavity. 27. Operations on the Heart. 28. Operations on the Great Vessels. 29. Operations for Leakage from Injured Thoracic Duct. 30. Trans-thoracic Vagotomy. VIII. Operations on the Esophagus. 31. Outline of Operative Procedures. 32. Operations for Conditions Resulting from Trauma. 33. Local Operations for Certain Benign Lesions. IX. Operations on the Esophagus (Contd.) 34. Esophagectomy. X. Abdominal Operations Performed Through Thoracic Incisions. 35. Transthoracic Gastric Surgery. 36. Transthoracic Splenectomy. 37. Transthoracic Adrenalectomy. 38. Transthoracic Nephrectomy. 39. Trans-thoracic Approach for Splenorenal Vein or Portocaval Anastomosis. XI. Surgery of the Diaphragm. 40. Congenital Defects. 41. Hiatus Hernia. 42. Defects Resulting from Injury. 43. Therapeutic Paralysis of the Diaphragm. Index.

Thoracic surgeons all over the world eagerly awaited the publication of Richard Sweet's book in 1950. At that time the book filled a very definite gap in thoracic surgical literature, and was welcomed chiefly on this account. The second edition is a very readable treatise on the subject and the sections on oesophageal surgery are particularly good, which is only to be expected from such a master.

The early chapters dealing with general principles, surgical anatomy, etc. will prove of value to those unfamiliar with this branch of surgery, although one may quibble with some of his statements, for example, the advocating of the introduction of small amounts of air following paracentesis thoracis in acute inflammatory conditions.

The section dealing with surgery of the lung is of value, but cannot compare with the more detailed and authoritative work of Richard Overholt. The account of cardiac operations has been

considerably expanded following recent advances in this field. In the first edition Mitral Valvotomy was dismissed with the comment that the procedure was not yet on a sound basis, neither technically or physiologically. In the present edition this attitude has been considerably altered, and Sweet's operation of the production of an extracardiac shunt, which was described at length in the first edition, has now been dismissed in one small paragraph. His comment that the operation may still be useful when access to the left auricle is difficult is hardly worthy of consideration. The recent advances in aortic valvular surgery are not described.

This book will not be of great benefit to most people concentrating on this field, but to those requiring a good survey of the subject, and to those unfamiliar with this field, this book is strongly recommended.

I.B.

CORRESPONDENCE : BRIEWERUBRIEK

THE MENACE OF THE HYPOTENSIVE DRUGS

To the Editor: Your recent Editorial on *The Choice of Treatment in Hypertension* prompts me to draw attention to a rather disquieting state of affairs which has developed in the past few years. I refer to the spate of cases I have encountered of what might be termed the 'hypotensive drug syndrome'. The cases consist of individuals subject to hypertension who have been bombarded with an unremitting salvo of various hypotensive drugs in sequence over many months or years. As might well be anticipated, many have developed an anxiety neurosis, often of severe degree.

Most of the cases have had a benign hypertension with every expectation of a fairly long and useful life ahead of them. In many instances the hypertension has been discovered accidentally during an insurance or other routine examination. Many were quite symptom-free until they were subjected to treatment.

A common story is as follows: First hexamethonium bromide was tried—perhaps 3 years ago. Eventually it was stopped because of untoward side effects, or because it was not found to afford the patient any significant benefit. By this time the dihydrogenated alkaloids of ergot have elbowed their way into fashion. They are tried and eventually discontinued. The patient is a little disappointed and a little poorer, for these are fairly expensive drugs if taken over a long period. But the doctor now has the phthalazine derivatives, the Veratrum alkaloids and Rauwolfia. Sometimes he discards one drug only to use it again unwittingly under a different trade name. And as each new drug is tried, the patient feels he must indeed be suffering from a very grave illness.

Such persistent and expensive efforts are being made, not with the expectation of curing his illness, but simply in the hope of somewhat lowering his blood pressure. And so he becomes more and more anxious and more and more desperate. Eventually, a man who may have been symptom-free when he came into the doctor's hands becomes depressed, anxious and full of neurotic symptoms. The improvement in these patients is quite dramatic when they are told that their prognosis is good and that they can discard all tablets.

Whilst some of these drugs are a little more effective than others, it is my experience that in only a small proportion of cases are they of practical value in producing a worth-while and sustained reduction in blood pressure. Even where they do achieve this, it is as well to remember that the underlying arterial disease still remains.

It is probably justifiable to use these drugs in the case of severe and malignant hypertension, and, by injection, for inducing a temporary fall of blood pressure; but I am convinced that their routine use in the mild and moderate cases of hypertension is not justified. Any dubious benefit they may exert on a condition which, untreated, is often compatible with a long and satisfactory life, is not justified by the introspection and anxiety they create. If it is decided to employ them, desperate switches from one to the other should be avoided. The practitioner should determine from his own experience, or in consultation, which drug or combination of drugs is likely to succeed and limit himself to these. The number of visits to the doctor should be reduced to a minimum.

It behoves us to remember the enthusiasm which, only a few years ago, greeted other treatments for hypertension, such as thiocyanate therapy, the rice diet and the Smithwick operation,

and to note the contraction of the claims made for them. The scientific importance of these new ganglion-blocking agents and central vasodepressors is undeniable, but from the point of view of practical clinical medicine I am convinced that the harm caused by their over-zealous administration far outweighs any good they may have done.

I dare to predict that the enthusiasm for their use in the routine treatment of hypertension will, in jazz parlance, prove only a little less ephemeral than the popularity of the favourites in the 'Hit Parade'.

B. G. Shapiro, M.R.C.P. (London).

Dumbarton House
Adderley Street
Cape Town

I. Editorial (1954): S. Afr. Med. J., 28, 510 (19 June).

HYPOTENSIVE DRUGS

To the Editor: Your editorial comments (19 June)¹ on the multiplicity of hypotensive agents is timely, and your lead towards assessing their relative merits will be appreciated by many of your colleagues to whom this is a practical problem and not one of mere academic interest.

However, Sir, I am not in agreement with your rather sweeping condemnation of *Veratrum* alkaloids, although I do fully endorse what you have to say about hexamethonium, also a product marketed by my organization: therefore can I be credited with a reasonable impartiality of motives?

Can you, Sir, adequately support your statement: '*Veratrum* alkaloids are definitely not suitable for general use . . . They all (hexamethonium, *Veratrum* alkaloids etc.) carry a high morbidity and a definite mortality and in all of them it is most difficult to find that dose which is neither ineffective nor seriously hypotensive'—at least where single, crystalline alkaloids or the physiologically standardized, reproducible alkaloidal mixture known as 'Veriloid' are concerned? Were you possibly confusing crude extracts assayed by the now obsolete 'Craw' method, with modern scientifically controlled preparations, which are in the most extensive use throughout the world?

Your 'definite mortality' risk resolves itself on painstaking investigation into one single reported death during Veriloid therapy; even aspirin and household cough mixtures can look with envy at this record! Similarly, reports of excessive hypotensive action are remarkably absent from the medical literature which I study regularly.

I believe and hope that, on further reflection, you will incline to agreement with, for random example, a conclusion reached at a discussion on *Medical Treatment of Hypertension* which took place at a Royal Society of Medicine meeting in February 1952: '(With Veriloid) about 60% of cases respond to oral treatment and in 20-30% (of all cases) excellent results can be obtained. Combined with phenobarbitone and sodium intake below 0.5 gm. per day, Veriloid by mouth is a practicable treatment, especially for the younger severe hypertensive'. Or with Faust (1951), who in his letter to *The Journal-Lancet* (71, 65) concludes that '*Veratrum viride* has produced the most marked reduction of blood pressure

in the greatest number of cases'. He had to discontinue treatment in 1 case out of 40, over a 9 months' period.

R. E. Holmes

Riker Laboratories Africa (Pty) Ltd.

P.O. Box 1355
Port Elizabeth

I. Editorial (1954): S. Afr. Med. J., 28, 510.

(As stated in our article the literature on therapy is vast, consisting mostly of poorly designed 'therapeutic trials' with contradictory results. Authority could be quoted for almost every shade of opinion. For example, P. P. White and his colleagues (1953: Amer. Heart J., 46, 567) express the opinion that Protovetrine does not offer satisfactory protection from the serious complications of advanced hypertensive vascular disease. Miller *et al.*, using a *Veratrum* preparation found a poor response due to the 'narrow margin between tonic and therapeutic response', as did Miller and Mayer (1952: Arch. Intern. Med., 90, 567) using similar 'semi-purified' extracts.

'Further reflection' leads us to the same conclusion as we expressed previously, namely that these drugs require care and patience and a good round knowledge of their pharmacology, but that in spite of all their disadvantages their use is justified in hypertensives of some severity.—Editor.)

AFRIKAANS TRANSLATION OF NAME AND DEGREE OF COLLEGE OF PHYSICIANS AND SURGEONS

To the Editor: Though I am not actively engaged in the practice of medicine any more, I am nevertheless still a registered medical practitioner, and I have not as yet completely dissociated myself from the profession in general . . .

In my opinion the initials of the Afrikaans and the English should most decidedly be different. Keep them the same and there is interference with sovereign identity and the basis of future discontent and strife. Don't be misled by myopic and optative idealists: Be realistic, recognize the high and good right of Afrikaans to have separate initials, and the future will look after itself.

First of all, I wish to suggest that 'Fellow' be translated into 'Genoot'. In my opinion it will prove to be a happy, acceptable and accurate translation, which should readily and spontaneously become 'citizenized'. If my 'Genoot' be accepted, then it should follow naturally that the following further translations will fall into line:

Genoot van die Kollege van Interniste (G.K.I.).

Genoot van die Kollege van Chirurgie (G.K.C.).

Kollege van Interniste.

Kollege van Chirurgie.

May I, therefore, ask you kindly to bring my suggestion to the notice of the secretary of the steering committee of the college,¹ with especial emphasis on my key word of translation, viz. 'Genoot'.

Louis A. Fouché

Cape Town
4 July 1954

I. McMurray, T. B. (1954): S. Afr. Med. J., 28, 580 (3 July).

AFRIKAANS EQUIVALENT FOR 'FELLOW'

To the Editor: In his letter¹ Dr. T. B. McMurray, Hon. Secretary of the Steering Committee of the College of Physicians and Surgeons of South Africa, asks for proposals for a suitable Afrikaans equivalent for the word 'Fellow'. The entity 'Fellow' is of course a uniqueness of Anglo-Saxon culture, and its equivalent is unknown in nations outside the Commonwealth and the U.S.A. In Holland, for instance, memberships of various Societies exist of course, but not fellowships. It appears, therefore, that a neologism will have to be resorted to.

The equivalent of member is *lid*. I would like to propose that for fellow the word *fakulteitslid* is employed. Literally translated this is 'faculty member'. The word seems suitable because it is seldom, if ever, used in any other sense at present. One can describe a person today of course as being *lid van die fakulteit van medisyne*, which has the same ill-defined meaning in English: member of the faculty of medicine. The phrase *fakulteitslid van medisyne*, on the other hand, is never used. This illustrates my contention that the word *fakulteitslid* is there for the taking. It would imply a higher status than *lid*. One would then have *Lid van*

die Kollege van Interniste van S.A. and Fakulteitslid van die Kollege etc.

Dr. McMurray states that they are still undecided whether the initials of the Afrikaans and English versions should remain the same or whether separate initials would be necessary. As things now stand it is clear that separate initials are necessary. The word 'physician' for instance is quite different in Afrikaans (*internis*). This duplicity is not an ideal state of affairs. It is possible to have the same initials in both official languages, but then concessions, which will perhaps not be popular, will have to be made on both sides. Another, and perhaps the only satisfactory, alternative is to use Latin terms in designating the various divisions of the proposed College. This would eliminate the need for a dual nomenclature. Whether Latin can offer a suitable distinction between 'member' and 'fellow' I do not know.

A. D. Keet.

Department of Radiology
Groote Schuur Hospital
Cape Town

I. McMurray, T. B. (1954): S. Afr. Med. J., 28, 580.

FATAL AIR EMBOLISM

To the Editor: The report by Dr. Burrows¹ on *Fatal Air Embolism following Blood Transfusion*, and the correspondence it has elicited, serve to underline the fact that the study of Physics should be extended over the whole of the 6 years of the medical curriculum and not confined to the first year. If the laws governing the flow of fluids through tubes and orifices are intelligently applied it should never be necessary to subject any patient to the risk of air embolism during transfusion. Macintosh and Mushin² describe and illustrate a simple experiment which demonstrates this beyond doubt. I give the description in full:

'Fig. 147. A simple transfusion bottle and tubing have been set up. The level of the liquid in the bottle is 2 feet above the needle, inner bore 0.3 mm. In one minute 4.5 c.c. of liquid pass through the needle.

Fig. 148. By raising the bottle to 4 feet the original flow of liquid is approximately doubled. The flow through a tube is directly proportional to the pressure difference.

Fig. 149. The bottle is lowered to the original height (2 feet) and a larger needle, inner bore 1.0 mm., is substituted. The flow is 16 times greater than in fig. 147.

Moral. If a rapid flow of liquid is likely to be needed during a transfusion, use a large-bore needle in preference to relying on increase of pressure.'

With the small-bore (0.3 mm.) needle it would be necessary to raise the bottle to a height of 32 feet in order to obtain the volume-flow given with the larger bore (1.0 mm.) needle. With a pressure-head of 32 feet, the pressure at the needle would exceed 760 mm. Hg (equal to one atmosphere or 15 pounds to the square inch). To secure this pressure by pumping gas into the transfusion bottle is to invite explosive bursting of the bottle. It is obvious that increasing the pressure in the transfusion bottle can never achieve the happy result which is attendant upon increasing the size of the needle.

When it is considered inadvisable to risk over-hydration by maintaining an infusion pending the possible necessity for transfusion, a large-bore Lundy-Lewisohn stilette needle (manufactured by Messrs. Becton-Dickinson, Rutherford, New Jersey, U.S.A.) may be inserted into a convenient vein and fixed in place. Should infusion or transfusion later become necessary, the stilette can be withdrawn, the infusion apparatus connected to the needle and the infusion or transfusion administered forthwith. These needles are obtainable in various sizes, up to size No. 13. With a No. 15 needle and 6 feet of pressure-head it is easily possible to transfuse 100 c.c. of citrated whole blood per minute. It is, of course, often possible to administer 2 or more transfusions concurrently to the same patient.

C. S. Jones

Head of the Department of Anaesthesia

Groote Schuur Hospital
Cape Town
26 June 1954

1. Burrows, E. H. (1954): S. Afr. Med. J., 28, 436 (22 May).
2. Macintosh, R. R. and Mushin, W. W.: *Physics for the Anaesthetist*, pp. 136-137. Oxford: Blackwell Scientific Publications.

STOP

DETOUR

BY-PASS

at the very first sign of a cold

its development—

antihistaminic therapy has been reported to abort the development of the common cold in 90% of the patients commencing therapy within the first hour of the appearance of symptoms.¹

distressing symptoms—

antihistaminic therapy shortens the duration and decreases the severity of an established cold.^{1,2}

spread of infection to others—

the elimination of sneezing, lacrimation, rhinorrhoea and coughing reduces cross-infection.¹

CORICIDIN

(Antipyretic-analgesic-antihistaminic)

combines the classical "A.P.C. formula" (Acetylsalicylic acid 3.5 gr., Acetophenetidin 2.5 gr. and Caffeine 0.5 gr.) with Chlor-Trimeton* the antihistaminic with minimal side-effects and greater effectiveness in doses as low as 2.4 mg.³

The Allergic Concept of the Common Cold: The symptoms of upper respiratory infections closely resemble those found in vasomotor rhinitis and hay fever. More histamine-like substances were found in the nasal secretions of persons suffering from colds than in allergic rhinitis.

Dosage and Timing: Two CORICIDIN Tablets at the very first indication of a cold, then one tablet every three or four hours for three or four days. In established colds, one tablet every three or four hours for palliative effect.

Packing: CORICIDIN Tablets, tubes of 12, bottles of 25 and 100.

Bibliography: 1. Brewster, J. M.: *Indust. Med.* 18:217, 1949. 2. Murray, H. C.: *Indust. Med.* 18:215, 1949. 3. Tislow, R. and others: *Federation Proc.*, Part 1, 8:338, 1949. 4. Troescher-Elam, E.; Ancona, G. R., and Kerr, W. J.: *Am. J. Physiol.* 145:711, 1945. *T. M. Schering Corporation.



Schering

CORPORATION, BLOOMFIELD, N.J., U.S.A.

Sole Distributors

SCHERAG (PTY.) LTD. P.O. BOX 7539
JOHANNESBURG



CAFERGOT

(Ergotamine tartrate 1 mg+caffeine 100mg)

FOR ORAL TREATMENT OF

VASCULAR HEADACHES

HISTAMINE CEPHALGIA

TENSION HEADACHES

MIGRAINE

DOSAGE.

(a) First attack treated with Cafergot.

Two tablets should be taken at the first symptoms of an impending attack. If the headache is not aborted, further tablets may be taken every 30 minutes until the headache is stopped, up to a maximum of 6 tablets.

(b) Treatment of subsequent attacks.

Once the total dose required to check an attack has been determined (see a) the total number of tablets should be taken as a single dose on the first warning of an attack. However, not more than 4 tablets should be taken as a single dose.

Maximum doses:

Six tablets for any one attack.

Ten tablets in any week.

CONTRAINDICATIONS:

Angina pectoris

Peripheral vascular disease

Impairment of renal or hepatic function

Pregnancy

Available in tubes of 20 and in bottles of 100 tablets.

SANDOZ LTD. BASLE SWITZERLAND

Samples and Literature upon request from:

ALEX. LIPWORTH LTD., SANDOZ PHARM. DEPTM., P.O. BOX 4461, JHB.

LACTOGEN

for infant
feeding

Advantages

* 1. Scientifically balanced analysis. 2. Standard and constant composition. 3. Freedom from bacteriological contamination. 4. Easy digestibility. 5. Lasting freshness. 6. Simple preparation. 7. Contains added Vitamins A and D. 8. Mineral content supplemented by the addition of a small but sufficient amount of iron (Ammonium Citrate).

* Comparative Analysis:

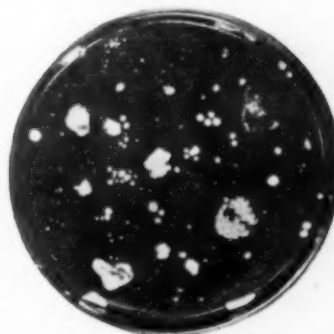
	BREAST MILK (Average)	LACTOGEN * (Reconstituted)	COW'S MILK (Average)
FAT	3.50%	3.03%	3.5%
PROTEIN	1.25%	2.11%	3.4%
LACTOSE	7.00%	6.64%	4.7%
MINERAL SALT	.20%	.45%	.7%
WATER	88.05%	87.77%	87.7%

(* LACTOGEN reconstituted with 7 parts water by weight.)

If breast feeding is inadequate or fails, LACTOGEN can safely replace breast milk either partly or completely. It is spray-dried full cream milk modified so that on reconstitution with water, a milk mixture closely resembling human milk in percentage composition is obtained.

Bacterial Purity

ORDINARY MILK	LACTOGEN
1/1,000 c.c. plated—over 200,000 bacteria per c.c.	1/10 c.c. plated—less than 100 bacteria per c.c.



ORDINARY MILK



LACTOGEN
Full Strength Mixture





*The man who maintains that
VICEROY is "the finest cigarette
money can buy" always places
himself in a strong position.*

*Firstly because the only judge of a
cigarette is the person who smokes it.*

*Secondly because weight of opinion
is always on
his side.*



Will's **VICEROY** *of course!*

PLAIN • CORK • FILTER

U.V.213

We are pleased

to inform you that we have reorganised our Factory by introducing new methods of production and importing the most modern machinery to bring down the cost of printing drastically and to guarantee prompt and efficient delivery.

The Medical Association of South Africa

the publishers of this Journal, have done us the honour to appoint us as their printers. But they do not stand alone in this wise choice, because a large number of other publishers whose names have become household words, have found it both profitable and expedient to entrust their printing to us.

We cordially invite you

to share in the benefits of decreased costs, enhanced efficiency, better quality and more expeditious delivery —

By placing a trial order

with

**NATIONAL COMMERCIAL PRINTERS,
LIMITED**

P.O. BOX 120, PHONE: 98-6711, PAROW.

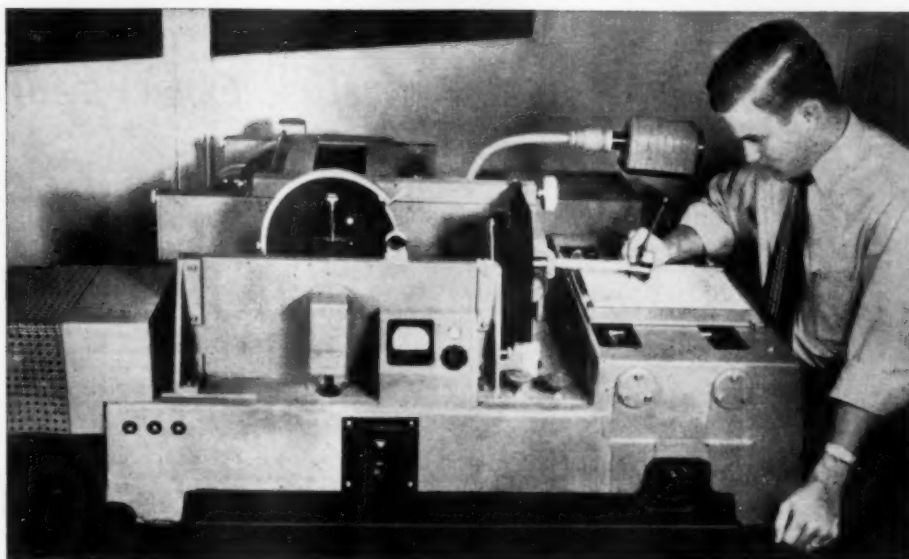
or Sales Division:

2, LEEUWEN STREET, PHONE: 2-9381,
CAPE TOWN.

BLUE BRAND FILM . . .

Dependability

ASSURED



Before it is approved for shipment, Kodak Blue Brand X-ray Film must prove its uniformity. Hour after hour, day after day, strip samples of finished film are carefully exposed, processed, and tested in this recording densitometer.

Every radiologist using Blue Brand Film receives the benefit of 63 years of knowledge, experience and skill in film manufacture—solid assurance of dependability and uniformity, promise of continuing improvement.

KODAK (SOUTH AFRICA) LIMITED

CAPE TOWN

• JOHANNESBURG

• DURBAN

'Kodak' is a registered trade-mark

Introducing

H I C O S E E N

H O M M E L

A new, highly effective expectorant on an original basis

The principal constituent of 'HICOSEEN' is 2-Diethylaminoethyl-phenylethyl-acetate, synthesized by Hommel and for the first time clinically used. It acts broncholytically and at the same time sedatively on the cough reflex.

'Hicoseen' provides the basic requirements of anti-tussic therapy: repression of cough reflex and promotion of expectoration. These are accomplished with a very high degree of compatibility.



PHARMACOLOGY

Absence of side-effects, including drowsiness, is of outstanding importance. The respiratory centre not being acted on in any way, the cough reflex is probably influenced by a mechanism different from that of morphine alkaloids. 'Hicoseen' contains such a small dose of codeine phosphate that even high overdosage is innocuous.

COMPOSITION

2-Diethylaminoethyl-phenylethyl-acetate	0.1%
Codeine phosphate	0.08%
Guaiacol albuminate	5.25%
<i>in pleasantly flavoured syrup</i>	

INDICATIONS

Specific in cough irritation, bronchial catarrh, bronchitis, tracheo-bronchitis in emphysema and pulmonary tuberculosis.

DOSAGE

Adults: 2 to 4 tablespoonfuls; in cases of cough irritation 1 to 10 teaspoonfuls daily.
Children: according to age and number of cough paroxysms 3 to 5 tea- or dessertspoonfuls daily.

PRESENTATION

'Hicoseen' Syrup is available in bottles containing 4 fluid oz; also in 16 fluid oz. bottles for dispensing.

PROFESSIONAL SAMPLE AND LITERATURE ON REQUEST

HOMMEL'S HÆMATOGEN & DRUG CO., 121 Norwood Road, London S.E.24

Our Sole Agents for SOUTH AFRICA: MESSRS. LENNON LIMITED. P.O. Box 39, Cape Town. P.O. Box 24, Port Elizabeth.
P.O. Box 266, Durban, Natal. P.O. Box 928, Johannesburg, Transvaal. P.O. Box 76, East London. P.O. Box 1102, Bulawayo,
Southern Rhodesia. P.O. Box 379, Salisbury, Southern Rhodesia.



*Highest peak concentrations and sustained
therapeutic effect with 'ESKACILLIN'
the palatable liquid oral penicillin*

Some authorities stress the value of high, if intermittent, peak penicillin serum concentrations; others favour lower but sustained, plateau levels.

With 'Eskacillin' the advantages of both patterns are available. A very high peak concentration is achieved within about one hour of the first dose, succeeded by a more than adequate therapeutic level sustained for several hours.

'ESKACILLIN' 50

'ESKACILLIN' 100

M. & J. PHARMACEUTICALS (PTY.) LIMITED, DIESEL STREET, PORT ELIZABETH

(Associated with MENLEY & JAMES, LIMITED, LONDON)

6CP345A

for Smith Kline & French International Co., owner of the trade mark 'Eskacillin'

Data on

*an important addition to the range
of M&B brand Contrast Media*

'DIAGINOL'

trade mark

SODIUM ACETRIZOATE

brand

Clinical experience to date indicates that sodium acetrizate can be used with advantage in most or all of the procedures for which diodone solutions and iodoxyl have hitherto been used.

These are important points that mark its superiority:

- A** Fewer and less severe side-effects
- B** More rapid excretion allowing, in excretion urography, a shorter interval between injection and exposure
- C** Higher iodine content providing better shadows.

Detailed information on 'Diaginol' is available on request.

SUPPLIES:

30% solution in 20 c.c. ampoules
50% solution in 20 c.c. ampoules
70% solution in 25 c.c. ampoules
and in 50 c.c. bottles

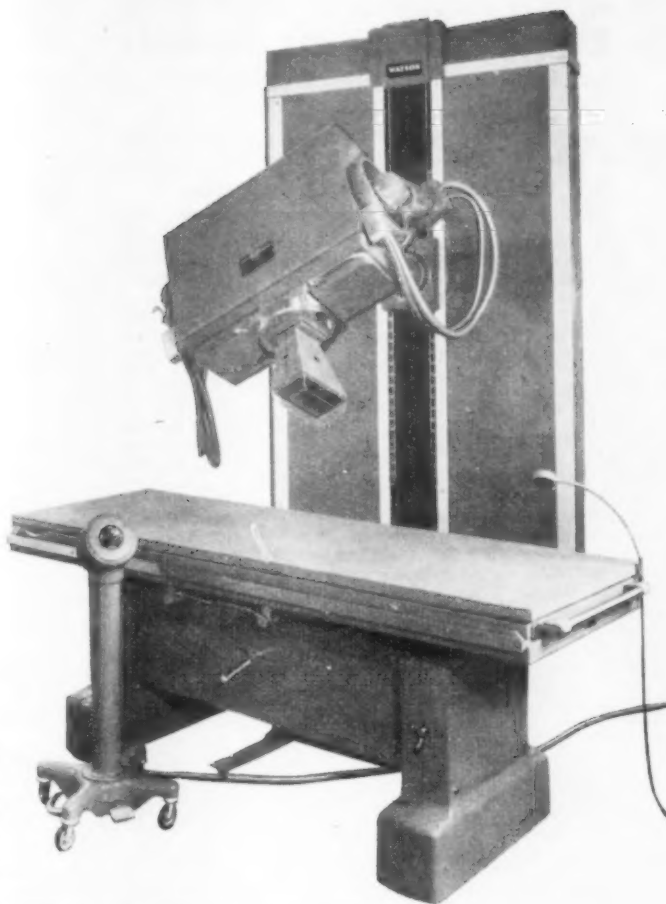


MANUFACTURED BY
MAY & BAKER LTD

DISTRIBUTORS

MAYBAKER (S.A.) (PTY.) LTD · P.O. BOX 1130 · PORT ELIZABETH Tel. 89011 (3 lines)

A reliable and efficient Deep Therapy apparatus



Experience in many of the leading radio-therapy departments in England and elsewhere has established the dependability and manipulative convenience of Watson Deep Therapy Apparatus Type XT-1.

It may be used continuously at 250 kV (peak) 18 mA yielding a dose rate of 50 roentgens per minute at 50 cm. F.S.D. free-in-air at a half-value-layer of 1.5 mm. Cu.

The Watson "divided generation" principle has made possible a tube-head of relatively small proportions which (aided by a motor-drive) may be positioned with accuracy. A complete range of applicators and filters is available.

Adequate arrangements exist throughout Southern Africa for installation and maintenance. May we send you full particulars?

WATSON & SONS (ELECTRO-MEDICAL) LTD.

Represented in South Africa and the Rhodesias by

THE BRITISH GENERAL ELECTRIC CO. (PTY) LTD.

Box 1327, Cape Town
Box 922, Durban

Box 2406, Johannesburg

Box 914, Bloemfontein
Box 42, Port Elizabeth

THE BRITISH GENERAL ELECTRIC CO. OF CENTRAL AFRICA LTD.

Box 1070, Bulawayo

Representing

Box 845, Salisbury

THE GENERAL ELECTRIC CO. LTD. OF ENGLAND

The Medical Association of South Africa Die Mediese Vereniging van Suid-Afrika

AGENTSAP-AFDELING : AGENCY DEPARTMENT

JOHANNESBURG

Medical House, 5 Esselen Street. Telephones, 44-9134/5, 44-0817
Mediese Huis, Esselenstraat 5. Telefoon, 44-9134/5, 44-0817

PRACTICES AND PARTNERSHIPS FOR SALE

PRAKTYKE EN VENNOOTSAPPE TE KOOP

(Pr-S134) Transvaal. Old-established country practice. Gross income over £4,000 p.a. Partner with view to succession. Small initial capital required. House available to rent or to buy. Apply in writing, stating religion, marital status and experience.

(Pr-S132) Wes-Transvaal. Groot, vinnig-groeïende dorp met alle hospitaalgeriewe. Vennootskap van drie geneesher, waarvan een sy deel wil verkoop, om te spesialiseer. Die netto inkomste per jaar, per vennoot, is tussen £4,800 en £5,000. Hierdie is 'n ou-gevestigde praktyk met verskeie aanstellings. Verleslik 'n persoon met goeie ondervinding. Billike terme kan gereël word.

(Pr-S133) A half share is offered for sale in one of the premier general practices in Johannesburg. This is a busy practice and the prospective buyer should be energetic, hard-working, fluently bilingual and of a pleasant disposition.

(Pr-S125) Noord-Vrystaat. 'n Goeie praktyk met 'n netto inkomste van ongeveer £4,000 per jaar. Alle hospitaalgeriewe. Baie chirurgie word gedoen. Een oordraagbare aanstelling. Goeie geleentheid vir ervare persoon wie hom in 'n groot sentrum wil vestig. Volle besonderhede op aanvraag.

(Pr-S128) O.F.S. Country practice in a pleasure resort area, and unopposed, offers a wonderful opportunity for a doctor interested in Native practice. No night work. Ample scope for development. Full details on application.

(Pr-S115) Johannesburg. Helfte aandeel te koop in ou-gevestigde vennootskapspraktyk. Alle chirurgie word onderneem. Jaarlikse inkomste £3,000 per vennoot. Die premie vir hierdie eersterangse vennootskap is £2,500 en terme kan bespreek word.

(Pr-S135) Randse hospitaaldorp. Goed-gevestigde praktyk met 'n aanstelling en 'n inkomste van £3,000/£3,500 per jaar. Fienaar wil so spoedig moontlik verkoop om gesondheidsredes. Die premie kan maandeliks afbetaal word. Huis beskikbaar vir getroude persoon. Geen chirurgie word gedoen nie, maar baie geleentheid daarvoor. Volle besonderhede op aanvraag.

REGISTERED OBSTETRICIAN AND GYNAECOLOGIST

An Assistant, preferably Afrikaans speaking doctor, is required. The assistantship will be offered for one year—this may be reduced under certain circumstances. At the end of this trial period, a partnership will be offered. Very large and sound practice.

INSTRUMENTS FOR SALE

Brand new Zeiss Microscope, never been used. Cost £75, but will accept £65.

Westinghouse Diadex X-Ray and Siemens Heliosphere X-Ray. What offers?

* * *

DURBAN

112 Medical Centre, Field Street. Telephone 2-4049

PRACTICE FOR SALE

(PD25) Durban. House and practice available, suitable for a surgeon. Details on application.

(PD26) Transkei. Practice established 8 months ago. Average monthly turnover £126/£140. Two appointments held District Surgeon and M.O. to Native Recruiting Corporation. New outstation clinics could be opened. Trout and river fishing within 15 miles. Will consider any offer.

(PD27) Drakensberg Native Reserve area. Dispensing practice established February 1954 on part-time basis. Cash takings approximately £400. Buyer to take over drugs at cost, approximately £150 and equipment £60. Goodwill to be calculated as a percentage of the takings at the end of July.

(PD28) Durban. General practice also non-European surgery. Owing to ill-health owner wishes to sell as soon as possible. Before illness gross income £3,000 per annum. Premium £2,000. House for sale.

LOCUMS REQUIRED

Zululand. For two months or possibly longer. £2 12s. 6d. per day, all found and car allowance.

ASSISTANT REQUIRED

(AM2) Assistant required for trial period. If suitable partnership will be offered. General practice in select area approximately 20 miles from Durban.

INSTRUMENTS FOR SALE

Two Electrocardiograph machines in first class order. Owner acquiring self-reading machine. Offers to be made.

Davidson Pneumothorax apparatus. Practically new. Any offer considered.

Super-sonic (Impulsaphon) Machine in perfect condition. £250 immediate sale.

* * *

KAAPSTAD : CAPE TOWN

Posbus 643, Telefoon 2-6177 : P.O. Box 643, Telephone 2-6177

Waalstraat 35

35 Wale Street

PRACTICES FOR SALE : PRAKTYKE TE KOOP

(1399) Transkei. Unopposed prescribing practice. Cash receipts 1950/51/52—£3,887, £4,814, £5,064. Two appointments. Practically no night work. Premium required £2,200. Large house for sale at £2,300. Jeep also offered for sale. Terms possible.

(1436) Goedgevestigde Karoo-praktyk. Ontvangste ongeveer £3,000 p.j. D.S. en M.O.H. aanstellings. Koopprijs £1,500 wat voorrade insluit. Gerieflike woning met spreekkamers beskikbaar teen besonder billike huurgeld.

(1276) S.W.A. hospital town. Well-established prescribing practice. Cash income=£3,879 p.a. THIS IS AN EXCELLENT OPPORTUNITY to acquire a very good practice with full scope for surgery at an exceptionally low premium as the owner wishes to sell as soon as possible in order to specialize. Premium for goodwill, instruments and excellent surgery furniture £1,600. Terms possible.

(1662) Ongeopponeerde eenmanspraktyk in Bechuanaland. Totale bruto-ontvangste, 1951/52/53—£4,000/£4,500/£4,690 plus D.S. ±£2,500. Premie van £3,000 sluit in geneesmiddels, instrumente, apteekameublement ens.

(1684) 'n Ou gevestigde praktyk in Noord-Oos-Kaapland word dadelik te koop aangebied. Enige redelike aanbod sal aanvaar word. Terme vir afbetaling kan gereël word. Verder besonderhede op aanvraag.

(1679) KAAPSTAD. UITSTEKENDE VOORSTEDELIKE PRAKTYK. BESONDERHEDE OP AANVRAAG.

ASSISTENTE/PLAASVERVANGERS VERLANG

ASSISTANTS/LOCUMS REQUIRED

LOCUMS AND OR ASSISTANTS ARE URGENTLY REQUIRED FOR URBAN AND RURAL AREAS. DETAILS ON APPLICATION.

CONSULTING ROOMS AVAILABLE

CENTRALLY SITUATED IN CAPE TOWN.

(1693) Sole use of one consulting room. Share facilities of sterilising room, waiting room and secretarial and receptionist services. Reasonable Rental.

(1694) Fully furnished consulting room with waiting room and receptionist services in central position Cape Town, afternoons only. Low rental.

INSTRUMENTS FOR SALE

(1694) Sanborn Cardiette in perfect condition complete with two cassettes. Price £55.

(1587) Zeiss Winkel Microscope (91385) with 3 lenses. Oil immersion and 2 eyepieces £60. Hand Centrifuge £3.5.0. Haemocytometer £3.16.0.

These instruments are new but available at reduced prices.

VALUABLE BOOK FREE!

ARE YOU PREPARING FOR ANY MEDICAL,
SURGICAL, or DENTAL EXAMINATION?
Send Coupon below for our valuable publication

"GUIDE TO MEDICAL EXAMINATIONS"

PRINCIPAL CONTENTS

The Examinations of the Conjoint Board.
The M.B. and M.D. Degrees of all British Universities.
How to pass the F.R.C.S. Exam.
The M.S. Lond. and other Higher Surgical Examinations
The M.R.C.P. London.
The D.P.H. and how to obtain it.
The Diploma in Anaesthetics.
The Diploma in Psychological Medicine.
The Diploma in Ophthalmology.
The Diploma in Laryngology.
Diploma in Radiology.
The D.R.C.O.G. and M.R.C.O.G.
The Diploma in Child Health.
Coaching also for all South African Medical Examinations.
Do not fail to get a copy of this Book before commencing preparation for any Examination. It contains a large amount of valuable information. Dental Exams. in special Dental Guide.
SEND FOR YOUR COPY NOW!

.....
The Secretary,
MEDICAL CORRESPONDENCE COLLEGE
19 Welbeck Street, Cavendish Square, London W.1.
Sir,—Please send me a copy of your "Guide to Medical Examinations" by return.

Name.....
Address.....
Examination in }
which interested }
S.A.M.J. South African Offices: P.O. Box 2239, Durban, Natal

Fellowships 1954

(1) Applications are invited from suitably qualified candidates who desire to be considered for the undermentioned classes of Fellowships of which, it is anticipated, that only two will be made available by the World Health Organisation:

- Mental diseases—with special attention to the hospitalisation and treatment of relatively short term cases.
- Pneumoconioses—with special reference to clinical manifestations and the assessment of disability.
- The National Health Services in England and Scotland and their applicability, in whole or in part, in South Africa.
- Rural Dispensary schemes in other African Territories and their applicability in South Africa.
- Tuberculosis—with special reference to B.C.G. vaccination, domiciliary treatment and rehabilitation.
- Environmental Medicine—with special attention to the effect of climatic, racial and nutritional differences on health in Africa.
- Medical Education—with special reference to post graduate training.
- The training of medical and other health personnel.
- Epidemiology and Stastics.
- Food Hygiene.

(2) The duration of the fellowships will be approximately six months and the value will be:

A. Travel Status.

- 300 \$ per mensem in non-devaluated countries.
- 240 \$ per mensem in devaluated countries.

B. Resident Status (Applicable when the Fellow stays more than 15 days in one place).

- 200 \$ per mensem in non-devaluated countries
- 160 \$ per mensem in devaluated countries.

(3) As intimated in paragraph (1), *Fellowships will be limited to two in number and the grant of such fellowships will be subject to the provision of the necessary funds by the World Health Organisation as well as the final approval by that Organisation of the two candidates recommended.*

(4) Fellowships will be awarded only to graduates who are engaged, or will be engaged in public health services, medical education or medical research.
It should be noted that:

- the criterion for the award of a fellowship is the usefulness of the person to the above services and applications will be considered in this light rather than in the light of merit awards;
- awards from the limited resources of the World Health Organisation cannot be made to subsidize abstruse, academic research projects and consequently proposed programmes by candidates should be practical and should avoid excessive touring and visits to several countries. Programmes should allow for a few fairly long visits to countries whose institutions and services are most likely to provide training suitable for South Africa;
- as long as devaluation continues visits to the United States of America are exceedingly costly to the World Health Organisation and frequently have no very great advantage over visits to European countries providing institutions and services more comparable to those in South Africa.
- Successful applicants will be expected to give a written undertaking to the Organisation that they will either continue or enter the service of their national health administration for a period not less than three years following completion of their course of studies. The term national health administration covers all forms of whole-time public medical service including research and education.

(6) An award of a fellowship will include transportation and related expenses from the country of origin to the country of study and return (that is, international travel), stipend and authorised travel within the country of study, and such other expenses as may be specifically authorised by the Director-General.

(7) Travel within the Union of South Africa or South West Africa not included in the international travel ticket provided by the Organisation, will be the financial responsibility of the Fellow himself.

(8) Candidates must be South African citizens or citizens of a Commonwealth Country or citizens of the Republic of Ireland and have resided in the Union of South Africa or in South West Africa for a period of at least three years.

(9) Application forms are obtainable from the Secretary for Health, P.O. Box 386, Pretoria. When submitting a request for an application form it should be stated for which of the fellowships, indicated under paragraph (1) above the candidate desires to be considered.

(10) It will be the responsibility of the successful applicant to arrange with his present employer for leave of absence for the purpose of accepting the Fellowship. As far as Public Servants are concerned particulars of the basis on which leave of absence will be granted can be obtained from the Secretary for Health, P.O. Box 386, Pretoria.

(11) Completed application forms will be received up to and including 31 July 1954. Forms received after that date will not be considered.

FOR SALE

Westinghouse 30 Ma Portable D Self Contained X-Ray Unit. In daily use. Reason for selling, have purchased larger unit. £460. Apply to A.V.R., P.O. Box 643, Cape Town.

Stadsraad van Ventersdorp

VAKATURE:

DEELTYDSE MEDIESE GESONDHEIDSBEAMPTTE

Aansoek vir die betrekking van deeltydse Mediese gesondheids-beampte teen 'n salaris van £10 0s. 0d. per maand, word van gekwalifiseerde mediese praktisyns ingewag deur die Stadsraad van Ventersdorp.

Aansoek moet op die Raad se amptelike aansoekvorm, verkrybaar van die ondergetekende, ingedien word voor of op Woensdag, 28 Julie 1954 om 4 nm.

Die aanstelling van die suksesvolle applikant is onderhewig aan die goedkeuring van die Departement van Gesondheid en onderwys aan die ondertekening van 'n kontrak.

Bewys van persoonlike stemwerwing, direk of indirek, sal 'n applikant vir die betrekking diskwalifiseer.

Munisipale Kennisgewing Nr. 23/54.
Ventersdorp.
29 Junie 1954.

Johan S. van Onselen
Stadsklerk

Town Council of Ventersdorp

VACANCY: PART-TIME MEDICAL OFFICER OF HEALTH

Applications for the vacancy of part-time Medical Officer of Health, at a salary of £10 0s. 0d. per month, are hereby invited by the Town Council of Ventersdorp from qualified medical practitioners.

Applications must be submitted on the Council's official application form, obtainable from the undersigned, on or before Wednesday, 28 July, 1954, at 4 p.m.

The appointment of the successful applicant is subject to the approval of the Department of Health and the completion of a contract.

Proof of personal canvassing, directly or indirectly, will disqualify an applicant from appointment.

Municipal Notice No. 23/54
Ventersdorp.
29 June, 1954.

Johan S. van Onselen
Town Clerk

Instruments For Sale

As used by Sir R. C. Brock of Guys Hospital for performing Mitral Valvotomy. They are all the very latest pattern, made by the G.V. Manufacturing Company Limited, and recently imported from England. Perfect condition, many have never been used.

- 2 Tudor Edwards scapula retractors.
 - 1 Holmes Sellors thoractomy retractor, latest model with 3 sets of blades and key.
 - 1 Allison's lung retractor.
 - 1 set of 3 auricular clamps, Brocks pattern.
 - 1 Manometer, two piece with needle and tap.
 - 1 set Brocks Mitral valve knives, medial and lateral blades and finger piece.
 - 1 Pr McIndoes forceps.
 - 1 Pr McIndoes scissors.
 - 1 Pr Nelsons lobectomy scissors.
 - 1 Buttock support } with attachments to fit Allen and
 - 1 Pelvic support } Hanbury's operating tables.
- Price £150 for the complete set. Write to A.V.S., P.O. Box 643, Cape Town.

Rhokana Corporation, Limited

GENERAL PRACTITIONER

A vacancy exists for an experienced general practitioner at the Nkana copper mine in Northern Rhodesia. In addition to salary and a cost of living allowance, a copper bonus is paid; a house will be available at a nominal rental.

Special consideration will be given to applicants qualified, or experienced, in midwifery and gynaecology.

Applications, giving full personal particulars and stating details of qualifications and experience, should be addressed in writing to:

The Personnel Officer,
P.O. Box 4587,
Johannesburg.

Provincial Administration of the Cape of Good Hope

HONORARY MEDICAL APPOINTMENT

Applications are invited from registered Medical Practitioners under the age of sixty years for appointment to the post of General Practitioner (Surgical Division) at the Victoria Hospital, Wynberg.

The successful applicant will be required to assume duty on 1 September 1954.

The annual honorarium payable before the thirty-first day of March of each year shall be calculated by multiplying the average number of in-patients treated in the hospital during the preceding calendar year by £10, provided that no member of the honorary medical staff shall be apportioned more than £105 per annum.

Applications stating age, qualifications, etc., should be forwarded to reach the Medical Superintendent, Central Office, 58 Loop Street, Cape Town, or P.O. Box 1487, Cape Town, not later than noon on Friday 6 August 1954.

A560638

Provinsiale Administrasie van die Kaap die Goeie Hoop

ERE-MEDIESE AANSTELLING

Aansoek word ingewag van geregistreerde mediese geneesher onder die ouderdom van sestig jaar vir aanstelling tot die pos van Algemene Geneesheer (Mediese Afdeling) by die Victoria-hospitaal, Wynberg.

Die suksesvolle applikant moet dienste aanvaar op 1 September 1954.

Die jaarlikse honorarium betaalbaar aan die ere-mediese personeel voor die een-en-dertigste dag van Maart elke jaar sal bereken word deur die gemiddelde daaglikse getal binnepasiënte wat gedurende die voorafgaande kalenderjaar in die hospitaal is, met £10 te vermenigvuldig, met dien verstande dat geen lid van die ere-mediese personeel meer as £105 per jaar mag ontvang nie.

Aansoek wat melding maak van ouderdom, kwalifikasies ensovoorts moet gestuur word aan die Mediese Superintendent, Sentrale Kantoor, Loopstraat 58, of Posbus 1487, Kaapstad, om hom nie later as twaalf middag op Vrydag, 6 Augustus 1954 te bereik nie.

A560638

Appointment of Full-Time Additional Assistant Medical Officer

Applications are invited for the post of Additional Assistant Medical Officer. The salary will be Ninety pounds per month together with a cost-of-living allowance of Twenty pounds per month.

Qualifications being equal, preference will be given to married applicants of not less than two years post-internship experience.

An unfurnished house will be provided free for a married doctor. In the case of a single man being appointed he will reside at a local hotel where he will be responsible for his own living expenses.

A vehicle is provided but solely for use in the performance of company medical duties.

The successful applicant will be expected to participate in the Company Group Life Insurance and pension scheme.

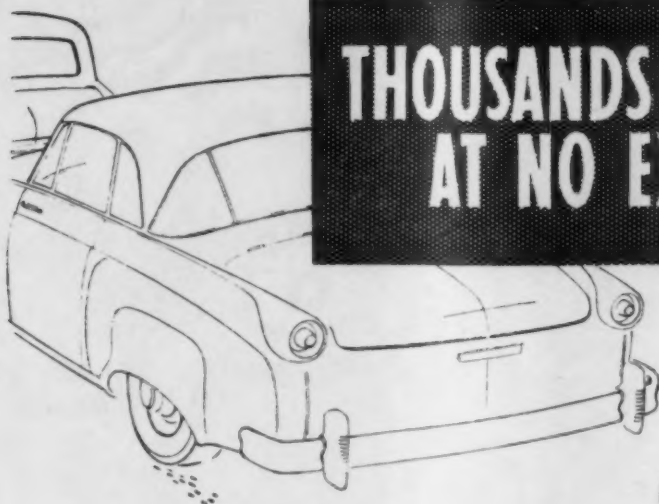
Commencement of duty is to take place on or as soon as possible after 1 September 1954.

The prescribed application form and full particulars concerning the appointment may be obtained from the Chief Medical Officer, O'okiep Copper Co., Ltd., Nababiep, C.P.

(This appointment has the approval of The Medical Association.)

WAX LEG BATH

Almost new. Wax included. £15 cash. Phone 6-2494, Cape Town.



**THOUSANDS OF EXTRA MILES
AT NO EXTRA COST**



that's why
in South Africa more
people buy Firestone
than any other make

Firestone
tyres are so

CONSISTENTLY GOOD

Enjoy "The Voice of Firestone" over Spring-
bok Radio on Thursdays at 8.30 p.m. and
from Lourenco Marques on Mondays at 8 p.m.



**The
ideal
nasal
decongestant**



FENOX
NASAL DROPS

Prompt Effect

Low surface tension—readily absorbed by the mucosa.

Prolonged Action

The prompt, sustained effect of Fenox gives prolonged relief with small dosage.

Non-Oily

Fenox does not interfere with ciliary action and there is no danger of lipoid pneumonia.

Viscous

Fenox has the same viscosity as mucus and remains at the site of action.

Non-Irritant

Fenox is pH-adjusted and isotonic with the nasal secretion.

Non-Toxic

Free from undesirable side effects—suitable for children and adults.

**For the treatment of
catarrhal conditions**

FENOX, the only preparation containing phenylephrine hydrochloride and naphazoline nitrate, marks an advance in the local treatment of catarrhal conditions of the nasal passages and accessory sinuses. It exhibits all the properties of the ideal nasal decongestant.

FENOX is supplied in ½ fl. oz. dropper bottles and is available at low cost.

B.P.D. (South Africa) (Pty) Ltd., P.O. Box 45, Jeppestown, Transvaal
BOOTS PURE DRUG CO. LTD. NOTTINGHAM, ENGLAND

